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ABSTRACT

Presenting multi-ethnic views about the delivery of mental health services to the Hispanic population, this monograph contains 18 papers presented at the joint meeting of the Puerto Rican Medical Association's Psychiatry, Neurology and Neurosurgery Section, the Caribbean Psychiatric Association, and the American Psychiatric Association held in May 1976. The papers cover such topics as: the psychodynamics of prejudice; the evaluation and quality control of mental health services; the community mental health center in the central city--issues for administrators; clinical issues in the psychiatric treatment of Puerto Ricans; a community mental health program for Chicago's Spanish speaking people (8 years of evolution); psychiatric services to Puerto Rican patients in the Bronx; the importance of a community mental health center in a Spanish speaking community; diagnostic and prognostic surprises in Spanish American patients in Colorado; a separate complete program for Spanish speaking patients; the use of community workers in a Spanish speaking community; subtle bias in the treatment of the Spanish speaking; participation of Latinos and Blacks in outpatient services consumer surveys; day treatment of Hispanic adolescents involved with the courts; the language handicapped psychiatrist and patient in a bilingual situation; pharmacotherapy; voodoo, spiritualism and psychiatry; psychiatry and the criminal system; and the abused and neglected child. (NQ)

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TRANSCULTURAL PSYCHIATRY: AN HISPANIC PERSPECTIVE

Edited by

Eligio R. Padilla and Amado M. Padilla

with a Foreword by
Victor Bernal y del Río

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Amado M. Padilla, Principal Investigator
University of California
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Transcultural Psychiatry:
An Hispanic Perspective

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FOREWORD

The joint meeting of the Section of Psychiatry, Neurology and Neurosurgery of the Puerto Rican Medical Association, the Caribbean Psychiatric Association, and the American Psychiatric Association took place in San Juan, Puerto Rico in May, 1976. The Section of Psychiatry, Neurology and Neurosurgery, under the auspices of the Puerto Rico Institute of Psychiatry, organized and coordinated the meeting. The theme was "Psychiatric Services to the Spanish Speaking Population in the United States and Transcultural Aspects of Psychiatry in the Caribbean." Participants were invited to look with us and through us at particular services rendered to the foreign-born population in the United States and to the culturally different who are not in the mainstream of the "American Dream"; and to evaluate whether they all receive their due share of health and care.

The occasion was faced with many considerations. Was this to be called a congress, a meeting or an encounter? Was the theme "human services," or more specifically "psychiatric services"? Both inspection and introspection were required to answer these questions. Thus, we hesitated as we proceeded to invite other disciplines to participate. In order to make inspection thorough and introspection profound, it was decided that our emphasis must accentuate the relationship between the human and the humane. All services in which encounters occur, whether judiciary, police, health, education, etc., were selected as subjects for both internal and external scrutiny.

With the acceptance of this theme, it was possible to discuss the contributions of psychiatry and other mental health professions in a broader context including, but also going beyond, issues of traditional individual therapy. However, it is in fact our intensive study of the one-to-one encounter which enables psychiatrists to offer a different kind of positive input into the delivery of various types of human services. We stress the importance of considering the impact on the individual in the delivery of services. For example, who else has ever thought to teach and encourage handshaking between service deliverers (welfare workers, physicians, lawyers, parole officers) and their clients? Who else encourages kindergarten and primary grade teachers to hold their pupils on their laps? Who else would dream of making it imperative for a surgeon, judge or lawyer to shake hands with his client before beginning a case?

Certain trepidations to inaugurate any encounter or relationship is characteristic of the human being. The common, the frequent and the familiar produce a natural response to approach, embrace, accept and enjoy. The unfamiliar, the different, the unusual or the bizarre produce the opposite response; there is a tendency to avoid, to refuse and to reject. The same, the familiar, the common and the frequent are primitively but powerfully evaluated as "good"; the different, the unfamiliar, the uncommon, and the infrequent are similarly evaluated as "bad." This tendency becomes apparent when individuals come in contact with differing cultures producing what has popularly been referred to as cultural "shock."

Are psychiatrists susceptible to the same forces? We are trained to overcome this tendency and trained to deal with the uncommon, the unusual, even the bizarre. However, the training of psychiatrists and other mental health professionals focuses on individual variation. What appears to others to be uncommon or strange in individuals becomes to us what is expected and familiar. Yet, when encountering a person who presents not only his unique individuality, but also a different cultural identity, the same anxiety may be aroused in us.

The joint meeting was an unusual opportunity for participants to learn more about culturally diverse peoples and more about themselves. It brought together peers and neighbors who, through differences in language, cultural and ethnic origins, represent within themselves the different, the uncommon, the opposite, and some of which may have been described by members of "other" groups as bizarre. We came to identify our many similarities and to acknowledge and appreciate our differences as individuals and as members of different kinds of groups (including, among others, different nationalities, ethnic groups, and professional identifications) through the process of encounter. By contact, communication and increasing familiarity, we have lessened the impact and anxiety of the first encounter. Although repetition is the matrix of perfection, progress feeds on new experiences. Encounter with the new, the different, and the uncommon is what produces intellectual and emotional cross-pollination.

In closing, this experience bore such richness that we have been the subject of honors, applause, congratulations and embraces from all cardinal points, so much so that the encounter together with its success, became overwhelming. We cannot, however, afford to be humble, for we must share the pinnacle with so many in so many different ways. We accept the honors and accolades in order to share and distribute our thanks where they are due.

I especially wish to thank Mrs. Patricia Hall de Bernal, Ms. April Mayer and Ms. Marcia M. Smith for their assistance in planning and carrying out a successful conference.

Victor Bernal y del Río

PREFACE

One of the major objectives of the Spanish Speaking Mental Health Research Center (SSMHRC) is to collect and disseminate information that relates to the mental health of the Spanish speaking/surnamed population in the United States. In carrying out this objective, the SSMHRC periodically issues monographs which we hope will serve as a catalytic force in the developing dialogue on mental health issues and the Spanish speaking. The response to our earlier monographs has been positive and encouraging. Providers of mental health services have indicated that these publications have been useful to them in their work. Researchers have also informed us that the monographs have heuristic value. It has been our hope that the monographs would serve to sensitize policy makers about the mental health service needs (both in terms of quantity as well as quality of care) of the Hispanic population.

In December of 1975 Dr. Victor Bernal y del Río, Executive Director of the Hato Rey Institute of Psychiatry in Puerto Rico, wrote to us and outlined the agenda of a joint meeting scheduled for the following May. An invitation to edit and publish selected papers presented at the meeting was also included. Finding the goals of the joint meeting highly consistent with the objectives of the SSMHRC, the invitation was accepted. It was our opinion that the meeting being planned by Dr. Bernal y del Río was of such significance that the SSMHRC was obligated to assist in the dissemination of the proceedings of the meeting.

This monograph differs from earlier monographs published by the SSMHRC. First of all, the range of topics in this monograph is substantially broader, including such topics as child abuse, pharmacotherapy, psychiatry, social work, and the criminal justice system; also, psychiatry and spiritualism, and the developmental history of various mental health centers serving the Spanish speaking throughout the country.

The second major difference is that the monograph is truly national, even international, in perspective. Contributors represent various countries and distinct regions within countries. It follows, then, that the monograph presents multi-ethnic views about the delivery of mental health services to this country's Hispanic population. An assortment of mental health professionals from the United States—Anglo, Black, Chicano, Jewish, Puerto Rican—participated in the joint meeting with colleagues from the Caribbean, Mexico, South America, the Philippines and Canada. The monograph captures effectively the diversity in regional, national, ethnic and racial identifications.

The third major difference in this monograph was touched upon in the discussion of the range of topics. The monograph is clearly multidisciplinary in nature. Psychiatrists, social workers and psychologists all contributed to the collection of papers. To a limited extent, professional identity influenced the topic for consideration and the method used in its exploration. Empirically based reports, on the one hand, compliment essays based on clinical experience. Within the various disciplines there was also diversity in the kinds of activities in which individuals were involved which adds to the depth and breadth of the monograph. Private practitioners, community mental health center professionals and administrators, university-based mental health specialists and researchers, officials of national professional associations and representatives of state and federal mental health programs participated in the conference and contributed to this collection of papers.

The planning and implementation of a meeting of the magnitude of that held in San Juan, Puerto Rico required cooperation, persistence, patience and a good sense of humor. Dr. Bernal y del Río, the steering committee and others who assumed these responsibilities deserve credit for their skills in successfully carrying out such a major event. Hundreds of individuals participated in the panel discussions and the presentation of papers. Despite all this activity, the conference was not so large as to leave participants feeling alienated from the proceedings. It was a happening in which the opportunity to learn from others and to share one's professional and personal knowledge, experiences, thoughts and opinions, was remarkably and continually sustained. This volume is an attempt to convey some of what actually transpired at this meeting. Many papers were given and many panel discussions took place. It was impossible to include all papers and all discussion summaries in this monograph. Selection for inclusion in this volume was based on the editors' belief that some papers and discussion summaries bore more directly on issues affecting the mental health of the Hispanic population than did others. This determination, although subjective, was not intended to exclude any participant who prepared a paper for the joint meeting.

The title of this monograph signifies the major theme of the meeting assembled by Dr. Bernal y del Río in San Juan, Puerto Rico. A perusal of the Table of Contents attests to how the theme of the meeting became a reality. Finally, attention to the contributors of papers selected for this volume is testimony to the importance of the meeting, since so many well-known figures in the mental health professions were in attendance and contributed to the success of the San Juan Conference.

We owe a special debt of gratitude to Victor Bernal y del Río for making the opportunity available to us to assemble and disseminate the proceedings of the joint meeting. Whatever is of value in this monograph is attributable to his efforts. Likewise, whatever the weaknesses of the monograph may be, they are solely our responsibility.

We are also especially appreciative to Anne Treviño for her unfailing secretarial and editorial assistance in the preparation of this monograph. Without her quiet patience and skill this monograph might never have been completed because of the editors' rush to do a hundred and one other things around the SSMHRC. Victor B. Nelson Cisneros must also be thanked. Without his dedication to detail and schedules we might still be compiling the proceedings.

This volume is published as Monograph Number Four by the Spanish Speaking Mental Health Research Center, Amado M. Padilla, Principal Investigator, University of California, Los Angeles, California 90024, in the interest of achieving the broadest distribution of the ideas and recommendations contained therein. Copies may be obtained at a nominal charge from the Principal Investigator. The SSMHRC is funded by USPHS Grant 5-Rol-MH 24854 from the Center for Minority Mental Health Programs, Dr. James Ralph, Chief, National Institute of Mental Health, United States Department of Health, Education and Welfare.

Eligio R. Padilla
Amado M. Padilla
University of California, Los Angeles

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WELCOMING REMARKS

Bertram S. Brown
Director, National Institute of Mental Health

Friends and colleagues:

Greetings. The purpose of my remarks today are twofold: first, ceremonial or symbolic—to honor this occasion—and second, substantive—to briefly comment on the scientific and professional theme of the meeting. The challenge of blending and mixing these two purposes—ceremonial and scientific in a brief few minutes—seems in itself the very challenge of this meeting. A meeting which is attempting to creatively blend the United States and Puerto Rico—English and Spanish—even more boldly to bring meaning to the Caribbean and conglomerate of four languages and many nations and diverse peoples.

How to mix or blend these ingredients is the mystery, for each culture and each group and each people has its special characteristics and flavors; each has an internal desire to be autonomous and separate. Yet each cultural group must of necessity exist together in the same community, in the same family, and in the end, exist inside the same head, heart and soul of a single individual.

A challenge so deep demands more than science to describe it. One must turn to literature and poetry.

I turn to an unknown young man, Lucky Cienfuegos, who has spent his life going back and forth between New York and Lajas in southeast Puerto Rico and who has expressed his feeling in a poem entitled "The Influence of Don Quijote."

> Screws screwing spinning twirling
>   The mind moving
> The mood of time with the looney tunes
>   Transforming humans into cartoons
> Cold frozen ice cubes bathing themselves
>   in the veins of Don Quijote

To me, this theme of hot and cold has seemed a remarkable combination of climate and culture—the stark contrast of the cool New England handshake and the chest-crushing embrace of a Puerto Rican friend. This is well expressed by Noel Rico, a young Puerto Rican student of English, who put it this way, speaking of Puerto Ricans living in the mainland: "There is always a tendency to deny the American part and make a blind grab for the Puerto Rican part." But there should be an equal embracing of the two parts. To me, Luis Lloren Torres (for those who are unfamiliar with Torres, he was a Puerto Rican journalist-lawyer and poet who lived from 1878 to 1944) is just as much a part of me as Walt Whitman, and the differences between the languages is a question of temperature. English is colder, but the heat from the Spanish is rubbing off on the English.

Many of the scientific papers and symposium will deal with this problem of language. Fortunately, we have reached the point of awareness that for true understanding, so much more than literal or concrete translation, is necessary. In our own national legislation an important development is the mandating of bilingual services in health and mental health settings. Wherever possible, I have tried to make it clear that the issue for good services is not only bilingual, but bicultural. We have not yet fully faced the logistics of this issue, for even were it desirable to have only Blacks treat Blacks, Puerto Ricans treat Puerto Ricans, only WASPS care for WASPS, etc., etc., etc., it is not possible in the foreseeable future. I hope this meeting can make a contribution to this issue and define more clearly how people from one cultural, ethnic and language group can be trained to help care for people from a different group.

In conclusion in the search to bridge, to mix, to mend ceremony and science, let me turn from poetry to sports. A year or so ago El Mundo—the world basketball tournament—was held in Puerto Rico. Teams from many nations competed. I need not tell you, for example, the intensity of competition between Russia and the United States or Cuba and Jamaica. But one nation was special, for it had two teams: the United States team and the Puerto Rican team. For me, it expressed the special and difficult and emotionally charged relationship of Puerto Rico to the United States.

During the half-time of one of the games there was a bicentennial pageant showing English soldiers and revolutionary soldiers. I felt acutely uncomfortable and could sense the even greater discomfort and polarization in the Puerto Rican crowd. I wondered as to the sensitivity, if not the sanity, of the program planners to present this pageant.

When the United States and Russian teams were playing, I experienced the most massive sense of ambivalence. It wasn't only that part of the crowd was rooting for the Russians against the Americans, it was more that within the great majority of people there was genuine ambivalence.

In my opinion, this meeting is an unusual opportunity to deal with that ambivalence—at least to recognize it. We will also want to describe and understand it, and I know for me, and all of you, to rise above this ambivalence by utilizing both science and culture to recognize one common humanity.

THE PSYCHODYNAMICS OF PREJUDICE

Judd Marmor

The phenomenon of prejudice is not confined to differences in racial origin in human beings. It may also manifest itself in relation to differences in religion, differences in ethnic background, to ideological, class, caste, and political differences, to differences in age levels, and to variations in sexual preference. Its effects upon those who are prejudiced as well as upon victims of prejudice, in terms of aggression and counter-aggression, of human pain and suffering, are significant and widespread and the mental health of millions of people are directly or tangentially involved in its consequences. Accordingly, it is both proper and legitimate that psychiatry should concern itself with this phenomenon, with its psychodynamic roots as well as its other sources, and with the problem of how it can most effectively be dealt with.

The etymological roots of the word prejudice give us some clues to its basic meaning. It is derived from the Latin *prejudicium,* which means prejudgment or a premature judgment. Thus, the term prejudice implies an attitude based on insufficient knowledge. It is, to put it colloquially, being down on something you are not up on. Although this colloquial definition emphasizes prejudice in its negative connotations, it is important to note that prejudice can also be positive, that is, it can imply an equally distorted judgment in favor of a particular order of things or people. However, it is usually used in its negative connotation and it is with that aspect that I shall concern myself today.

There are two other features connected with the phenomenon of prejudice that add depth to our preliminary definition of it: (a) a tendency to generalize from the particular, and (b) an imperviousness to logic. The tendency to generalize from the particular is part of the phenomenon also known as stereotyping. It implies a tendency to attribute qualities to an entire group based on only limited experience with that group. Thus, prejudiced individuals will often justify their stereotypic views about Jews, Catholics, Blacks, Spanish speaking Americans, homosexuals, etc. on the basis of the fact that they "once knew" or "once met" a person or persons from one or another of these groups who exhibited certain of the negative characteristics that were then being attributed to the entire group. It is important to note, however, that not all generalizations are necessarily prejudices. All people have a tendency to generalize to some degree on the basis of limited experience. Thus, the visitor to Europe will often come back from a two or three week

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sojourn with *ex cathedra* conclusions about the nature of the English, the French, the Italians, or the Russians. These generalizations, however, are not prejudices unless they become fixed and resistant to change. That is, a major test of whether a generalization is a prejudice is in the ability of the individual who holds such generalizations to change his or her mind in the light of new evidence. A prejudgment becomes a prejudice only if it is resistant to change when exposed to new knowledge.

This leads to the second important additional element in the definition of prejudice, which is its imperviousness to logic. One of the striking confirmations of the existence of prejudice is in the way in which mutually contradictory attitudes will often exist side by side in the mind of the prejudiced person. Thus, someone with prejudice against Blacks may be heard to accuse Blacks of being lazy and passive and then in another breath to complain about how aggressive and pushy they are becoming. Or they will argue that Blacks really don't want to change, that they are happy with things as they are, but in the next breath will complain that Blacks are trying to take over and that force is needed to keep them in their place. Similarly, people who are strongly anti-Semitic will often charge Jews with being stingy and miserly but again, almost in the same breath, will accuse them of vulgarly displaying their wealth by conspicuously spending. Such inherent contradictions in the attitudes of prejudiced people are confirmations of the fact that the roots of prejudice are not rational but stem from deeper emotional sources. Let us now turn to an examination of these deeper sources.

There are some who argue that there are inborn or instinctual roots to the phenomenon of prejudice and they adduce as evidence the way in which a cohort of hens will attack a strange hen that is introduced into the barnyard. Similarly, they call attention to the way in which all human infants tend to react with fear and anxiety to strangers, beginning at the age of about six months, and how such reactions to strangers and newcomers often persist to the age of two or three. The hostility with which a children's group will often react to a newcomer is given as another example of the "inborn" tendencies toward prejudice.

In fact, however, none of these phenomena are examples of prejudice, because in all of these instances the feelings of anxiety or hostility subside as the animals or children become accustomed to the strange face or the stranger. Rather than prejudice, these phenomena illustrate a universal tendency that exists in lower and higher animals as well as human beings to react with anxiety to the unknown and the unfamiliar. One of the major functions of the ego is to organize its perceptions of the environment in such a way as to reduce uncertainty, thus contributing to homeostatic needs for security and safety. Anything that introduces a new and unfamiliar element into a previously familiar environment causes an initial reaction of anxiety and suspicion until the new element becomes incorporated into a safe perception of the environment. After that, the new object is no longer feared or distrusted.

Genuine prejudice is impervious to experience and involves not only hostility to an individual but a stereotyping of the entire group to which he or she belongs. Such stereotyping is not innate in any way. Children who have not been conditioned or taught prejudice mix quite easily with other children of all races although their initial reaction to an unaccustomed appearance may be one of curiosity or even of mild anxiety. Like the song in "South Pacific," the hostile and dogmatic stereotyping of an entire group is something "you've got to be taught."

How, then, is prejudice acquired? There are two major ways, although the usual process involves a combination of both. The first of these is by passive adoption of environmental attitudes, usually from the parents or the in-group. This is fundamentally part of the acculturation process of a child growing up in a prejudiced setting. The child needs to belong and be accepted by the group and tends to accept unquestioningly the dominant values of that group. This, of course, is particularly true when the values are transmitted by parents who are loved or whose authority is unquestioned. This is a passive way of acquiring prejudice and people whose prejudice derives only from such acculturation that is not subsequently reinforced by other factors are often relatively educable and changeable in their prejudicial patterns if the dominant environmental forces or values change.

On the other hand, some individuals, even if their original prejudice was passively acquired, show great resistance to giving up their prejudiced views. In such individuals we often find certain personality patterns which render them particularly "prejudice-prone." For these individuals, prejudice serves an important psychodynamic need, a functional need. Such personality patterns are particularly apt to develop within the context of families where parents have been rigid, dominating, and authoritarian and have related to their children on the basis of power and fear rather than of trust and love. Children growing up in such families and with such parents tend to experience certain of their impulses, particularly sexual, aggressive, or rebellious ones, as dangerous and therefore tend to repress a great deal of hostility and guilt with regard to these impulses. When given an appropriate scapegoat, individuals with such repressed emotions tend to project and displace them onto the scapegoat. This leaves the prejudiced individual feeling "cleaner," "better," and "purer," than the scapegoat. Such prejudice-prone personalities tend to be repressed individuals who are usually quite unaware of their own inner forbidden feelings. They tend to utilize projection to discharge such forbidden feelings rather than to internalize them. Their interpersonal relationships are dominated by concepts of power rather than affection. Their adaptive patterns follow rigid rather than flexible lines. They show a considerable tendency toward polarization; that is, they think in terms of dichotomies. Things are seen by them as being all good or all bad, with no intermediate shadings. They suffer from deep feelings of inadequacy, usually compensated for by false feelings of superiority, by virtue of their scapegoating of other groups. In general, such individuals tend to be afraid of whatever is new or unfamiliar. Thus, the prejudice-prone individual is apt to be antagonistic to new ideas, fearful of new drugs, suspicious of new neighbors, and violently opposed to the invasion of his life space by immigrants from other shores.

However, to describe the roots of prejudice only in psychodynamic terms would not be entirely complete. As part of the outer system of forces in which prejudice develops, the effect of socioeconomic factors cannot be ignored. Such factors can intensify the feelings of insecurity and hostility that play a role in prejudice and scapegoating. Thus, such matters as competition for jobs, fears concerning real estate values, anxieties concerning school desegregation and the like, can play an important role in maintaining and intensifying feelings of prejudice. Efforts to maintain advantageous socioeconomic positions on the part of a dominant group in relation to a subordinate group, such as existed in the pre-war South or as continue to exist in Rhodesia and South Africa, are also commonly seen situations in which prejudice serves a functional value for the dominant group. Thus, we see that psychological factors and socioeconomic ones are often mutually reinforcing.

The phenomenon of prejudice in a group should not be confused with the phenomenon of group identity. Group prejudice involves ethnocentrism, a tendency to see one's own group as superior to all others, with an accompanying disparagement and stereotyping of other groups. It is a learned phenomenon. In contrast, the sense of group identity is an inevitable and constructive aspect of human life. The ethnicity that is implicit in group identity is a positive phenomenon in contrast to the negative aspects of ethnocentrism. It involves loving and respecting one's own group roots without disparaging others. The group can be regarded as an extended family. Just as it is not necessary to eliminate love of family to eliminate unfriendliness to strangers, so it is not necessary to eliminate ethnicity to eliminate prejudice. The elimination of prejudice should not be distorted to mean the elimination of ethnicity via total assimilation and loss of group identity. The world would be a poorer place without ethnic differences. Human culture is enriched tremendously by the cultural diversities contributed by different races, creeds, sexes, etc. A parallel can be drawn between the positive cultural consequences of the diverse mix of racial and ethnic contributions, and the positive biological consequences of not allowing a genetic pool to become too ingrown and inbred.

In some ways, the ability to retain positive group identifications and yet move on to the capacity to form good object relationships outside of the group can be considered an aspect of emotional maturation. What we often speak of as the resolution of the Oedipus complex involves the ability to move beyond the original nuclear family attachments to establish meaningful object relationships outside of the home and outside of the original parental attachments. One indication of emotional immaturity is revealed when individuals remain unduly attached to such extended family symbols as a fraternity or a sorority, to uncles or aunts, to one's home town, one's home state, or indeed one's nation. The ability ultimately to move beyond such sectarian attachments to a one world concept in which one is capable of appraising and responding to people of all races and all nations on the basis of their own merits, rather than as in-group or out-group members, can be considered a manifestation of emotional maturation. This should not be taken to imply that such mature people love everyone. It means rather that they become capable of evaluating people on their own merits rather than as stereotypes based on in-group or out-group myths. Neither does it mean that they stop loving their own families or in-groups. Indeed, we know from psychiatry that the capacity to love people who are close to us *increases* the capacity for loving others, also. The hatred of out-groups is not related to love of one's own group, but rather to feelings of inner inadequacy or insecurity. The ultimate objective of the elimination of prejudice is not assimilation of all groups into a single homogeneous one, but rather the elimination of false barriers between people or groups, the elimination of the "Berlin walls of prejudice," of sociocultural ghettos, and of obstacles to equal opportunity for all people regardless of race, color or creed.

The effects of prejudice are destructive both to the prejudiced person and to the victim of prejudice. In the prejudiced person it causes false feelings of superiority which often interfere with genuine accomplishment and self-fulfillment. Also, since the hostile behavior shown to victims of prejudice usually runs counter to the ethical values inculcated in most people, the maintenance of such prejudice tends to intensify unconscious feelings of guilt and self-loathing. This in turn intensifies the need to project their self-hatred on to external scapegoats, setting up a vicious cycle.

The effects on the victim of prejudice, of course, are more obvious. We see the tendency to an impaired self-image, and to defensive attitudes of denial, withdrawal, passivity, self-deprecation, dissimulation, and identification with the agressor. It is worth noting, however, that in recent years we have also seen indications of reparative attitudes that have been constructive. Not only has there been evidence of reactive hostility and "fighting back" but also the defense of the victimized group against prejudice sometimes may lead to a closer knitting together of the group and compensatory strivings with increased ethnic self-esteem. A classic example is the way in which Black people have turned their blackness, which was always considered a mark of inferiority, into a "black is beautiful" theme with an increased pride in their color.

We come finally to the question of how prejudice can be eliminated. Beginning with the individual and the family, a potent antidote against prejudice is a democratic upbringing in contrast to an authoritarian one. In families in which love, not power, is the basis for discipline and in which there is a respect for differences of opinion and of viewpoints, prejudice-prone personalities will not be apt to develop. Children who grow up with a reasonable self-esteem and without being forced to repress their sexual and hostile impulses will show less tendency towards scapegoating and projecting their guilty and hostile feelings onto others.

On the broader social scene, we find that merely educating people about the immorality or irrationality of prejudice is not enough in itself to eliminate it. People need actual changes in their life experiences in order to find out that their prejudiced views are in error. These changes in life experience can be regarded as analogous to what we call corrective emotional experiences in the process of psychotherapy. Thus, it is a matter of tremendous social importance to make possible contacts between different ethnic, racial and religious groups that will break down the prejudicial stereotypes that exist. Prejudice, like phobias, can be unlearned only if what is irrationally feared or hated is repetitively experienced and found to be nonthreatening. Thus, it becomes essential that at work, in school, in neighborhoods, in various organizations, and in the church, people can have relationships that will help to break down their prejudicial preconceptions. In order to make such experiences possible, history has shown that legislative enforcement is an essential preliminary measure. Contrary to the attitudes of some politicians who insist that nothing can be done about prejudice until the hearts of people have been changed, experience has demonstrated that legally enforced behavioral and experiential changes have to take place before attitudinal changes will occur. Thus, in this country, legally enforced desegregation in the army and in schools, neighborhoods and churches, has resulted in a rapid disappearance of prejudice in many of the individuals exposed to such legally enforced relationships. The fact is that the majority of people who have acquired their prejudices passively will give up their discriminatory attitudes if the law forces them to have experiences which contradict their prejudicial preconceptions.

The attitude of political leaders, however, is crucial in this regard. If political leaders support the law, experience has shown that the majority of their followers accept the changes and gradually relinquish their prejudices. On the other hand, if political leaders for various motivations choose to be ambivalent or antagonistic to the law, then the outcome is quite a different one. Events in Little Rock, Arkansas, in Georgia and other states of the South, as well as in the Boston desegregation problem, have illustrated how crucial the attitude of political leadership is in these matters.

The ultimate goal in the elimination of prejudice is not tolerance. Tolerance has in it the implication of condescension on the part of a superior group to an inferior group. The elimination of prejudice implies not tolerance but respect, respect for all who deserve respect, regardless of race, creed, or color, and the giving of equal opportunities to all people. In this bicentennial year of our nation the implementation of this goal becomes more important than ever before. Once and for all we must remove the schizophrenia in our moral life that prejudice creates. Then, and only then can we give reality to the great American dream of our founding fathers.

EVALUATION AND QUALITY CONTROL OF MENTAL HEALTH SERVICES

Robert W. Gibson

As physicians we have always recognized that evaluation of treatment is an essential tool for improving our therapeutic methods. Quality control is needed to maintain and to improve the level of care provided to our patients. These two activities, evaluation and quality control, have in the past decade assumed new significance.

During the sixties, public policy in the United States evolved to the point of declaring that adequate health care is the right of all persons, not just a privilege to be enjoyed by a few. The National Health Planning and Resources Development Act of 1974 (PL 93-641) in its statement of purpose stipulates: "The achievement of equal access to health care at a reasonable cost is a priority of federal government." You will note that this statement is hedging a bit. Equal access to quality health care is identified not as a right, but as a priority. And a condition is imposed—it must be at a reasonable cost. The determination of what is a reasonable cost will not be a medical decision; it will be a political decision.

Despite the fact that more than $30 billion are now provided annually by the federal government for health services to the elderly and the poor through Medicare and Medicaid, our nation has not been able to make good on the commitment of adequate health care for all. The escalation is staggering. During the past decade expenditures for health care have tripled, consuming 8.3 percent of the gross national product in 1975, as compared to 5.9 percent in 1965, with 42 percent currently coming from the federal government as compared to 25 percent in 1965.

There has been much debate as to whether the subsidy of federal and state funds created the monstrous problem of inflation of health care costs or simply made apparent existing inadequacies of funding and deficiencies in the health care system. The Planning Act does assert: "The massive infusion of federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to provide an adequate supply of distribution of health resources and consequently has not made possible equal access for everyone of such resources."

Despite this failure to provide adequate health care for all, there have been only modest increases in the benefits of most federal health programs during the past few years. Mental health programs have fared

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rather poorly and coverage for mental disorders is still not equal to coverage for general medical and surgical conditions. Indeed, many mental health programs, including community mental health centers, are being cut back. It appears that Medicaid will be cut in the coming year. This will hurt minority groups and the poor especially.

Generally speaking, rather little has been done to correct inequities in health care provided to minority groups and the poor. Only faint hope is offered by sections of the planning legislation that state: "Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health resources" and the inclusion as a priority: "The provision of primary care services for medically underserved populations, especially . . . economically depressed areas."

Emphasis is being placed on efforts to control, to reshape, and presumably to make the health care system more efficient and cost effective. For example, appropriations to assist health maintenance organizations aim to stimulate organized systems of health care as opposed to individual private practice. Social Security amendments mandating professional standards review organizations are designed to increase participation by physicians in review activities. The Planning Act establishes a vast network of local, state, and national citizens' groups to plan, to coordinate, and to control health resources. Manpower legislation, not yet enacted, but sure to come in the near future, will control that most important of all health resources—trained personnel.

It appears that the strategy is to hold back on national health insurance until the various controls are in place and working effectively. This reflects the suspicion of governmental planners that simply adding dollars does not improve the health of our nation.

The message is plain. Payers, whether they be federal or state government or insurance carriers, will make resources—dollars, personnel, facilities, supplies—available only to the degree that providers can demonstrate that they can use these resources effectively and efficiently. Evaluation studies and quality control takes on a new significance. Without them there will be no new health benefits.

This poses especially difficult problems for the field of mental health: (1) outcome studies are inadequate; (2) standards and criteria are not as yet available; and (3) it is difficult to balance humanistic concerns against cost effectiveness.

I personally welcome the increased emphasis on medical care evaluation and the overall expectations by governmental leaders for accountability from all elements of our society. But this is not an easy assignment for those of us in the health field. Note the stress on health, not just mental health. Somehow mental health has been singled out for special challenge. This is not a complaint, not a protest; the consumer and government have every right to ask us to demonstrate the effectiveness of mental health services. I simply want to put the issue into perspective.

Consider that the National Ambulatory Medical Care Service (NAMCS) estimates that in 1973-74 there were 14 million visits to physicians for colds, 18 million visits for back problems, 12 million visits for headaches, 12 million visits for fatigue, etc. This suggests that a great many visits to physicians were for illnesses for which there is no definitive medical treatment. Furthermore, many of these conditions were probably psychosomatic in origin. Judgments about outcome and cost effectiveness for these conditions are extremely difficult. Yet they are not challenged to the same degree as psychiatric services.

In the area of program evaluation there are particularly troublesome problems. It is not enough to judge the effectiveness of services provided. It is necessary to determine whether the needs of all members of the community are being met adequately. It is important to know whether all recipients of care receive treatment of comparable quality. Especially difficult problems are encountered by minority groups.

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from discriminating against patients on the grounds of race, color or national origin. It is not too difficult to identify blatantly discriminatory practices, but more subtle factors may impair the accomplishment of program goals. Among these factors are: (1) limited outreach services to minorities; (2) lower percentage of minority clients than exist in the catchment area population; (3) lower percentage of minority staff members than exist in the catchment area population; (4) lower percentage of minority advisory board members than exist in the catchment area population; (5) inaccessible locations; and (6) lack of bilingual staff members.

All of these factors can be of significance to the 19 million Spanish speaking people in the United States, but language difficulties are of special concern because they have the effect of limiting access to care, particularly if there is a lack of bilingual staff members. Because minority group members may have different expectations concerning the value of mental health services, outreach educational efforts are essential. Important needs that are particularly relevant to various minority groups in the community will surely be overlooked unless there is adequate representation at the level of those who decide on policy and priorities.

The type of treatment may be influenced by race and culture. Diagnosis becomes less accurate and treatment recommendations less specific with increased social-cultural distance between clinician and patient. It has been found that insight-oriented therapy is less likely to be recommended for members of minority groups. Alcoholics are more likely to be committed to prison than being channeled toward treatment. Attitudes of this type obviously arise from stereotypes and other perceptual distortions on the part of the staff.

Outcome studies including long-term follow-up are rare and must often rely on intermediate outcome variables. For example, treatment attendance is often assessed as an indirect measure of satisfaction with treatment. Higher treatment dropout rates are commonly found among members of minority groups. A review by Warheit (1974) of pertinent literature indicates that minority groups are usually found to have poorer recovery rates than others in the population.

There are a number of hypotheses to account for such differences; more severe symptomatology, differential treatment, culturally alien therapists, lack of faith in mental health services, staff attitudes, and so forth. Some of the problem may be in methodology. An NIMH report (Siegall, undated) concludes, "When patients come from minority groups or lower socioeconomic classes, the difficulty of determining the appropriateness and efficacy of treatment is particularly great." The key to most problems of providing, evaluating, and making services accessible to minority groups rests with the staff.

In discussing the response made by psychiatric residents to a survey, Gurel (1974) found that many respondents did not consider the understanding of minority cultures to be of importance and had made no special effort to gain better understanding of such issues. Still other respondents indicated that psychiatric residents could gain understanding of minority group members by simply being exposed to contacts with them in the course of their placements in community settings. Those who have studied this problem in greater detail believe that considerably more should be done.

For example, Miranda, in a Puerto Rican Task Force Report of 1973, (cited in Nelleun and Associates, 1975) recommends:

1. "Schools must contain a more balanced curriculum—both quantitative and qualitative, course content must have more relationship to organizational and community development and change . . ."

2. "Schools located in areas of Puerto Rican residency must develop a minimum of two specialized courses—one on the Puerto Rican experience and one on community issues and needs. In addition, content design by the appropriate faculty should be integrated into the rest of the school's curriculum. This presumes enough Puerto Rican faculty members to be able to work collaboratively with other staff."

Miranda stresses: ". . . a knowledgeable and articulate faculty of Puerto Rican background is necessary in any school to counterbalance the bias of the present written materials and to begin to introduce a point of view defined by the Puerto Rican himself rather than the non-Puerto Rican."

Participants of an NIMH Conference on Curriculum Development (Fiman, 1975) recommended that official policy enunciate certain measures, such as:

1. "Learning about individual minority groups by identifying their health needs and planning and implementing projects in response to those needs."
2. "Socioeconomic and demographic background materials on students entering courses in order to make individualized instruction based on student backgrounds."
3. "The presence in the classrooms of knowledgeable, articulate minority persons from an appropriate community to facilitate the learning process."

Returning to my central topics of evaluation and quality control, I would stress that these cannot be accomplished by isolated research studies; they must be made an integral part of the health care delivery system. Valuable as our traditional teaching rounds and clinical conferences are, they are no longer adequate to meet the complex demands placed on the health care system—especially our goal of making adequate health care accessible to all.

There are some encouraging steps being taken. The federal requirements for utilization review—even though aimed primarily at cost containment—do support medical audit studies and will stimulate all inpatient facilities to take a closer look at patterns of practice.

The Joint Commission on Accreditation of Hospitals (JACH) has added requirements for medical audit studies which will soon be applied to psychiatric facilities. The JACH in addition has developed a performance evaluation program that can be used by staff to achieve quality assurance. The American Hospital Association is making a comparable effort.

Professional standards review organizations (PSRO's) are beginning to look at psychiatric care. The American Psychiatric Association (APA) has been quite active in designing models that contain screening criteria that can be applied on a concurrent basis to a wide range of psychiatric conditions and treatment modalities to help identify instances in which the quality of treatment does not meet acceptable standards.

A further important, related step taken by the APA has been the employment of one of our members, Richard Dorsey, to serve as a consultant on peer review. He will be available to district branches to assist them in implementing peer review activities.

The federal government in its annually prepared five-year *Forward Plan for Health, 1976-80* places heavy emphasis on evaluation, noting—"the tracking and evaluation theme emerges from the growing recognition of the need for a systematic data base to guide and support health policy-making at every level of the American health care system. The need for data essential to health policy development and management of programs has increased geometrically with the public investment in health, the number of health services and resources supported, and the number of people receiving care.

The *Forward Plan* further indicates, "At present, extensive data gathering and analysis activities exist in nearly every segment of DHEW health programs. The utility of the large quantities of data flowing from these and other data systems is diluted by three factors: (1) the lack of coordination in the collection of data or standardization across program needs; (2) the gaps in data collected; and (3) the lack of analysis of the data collected and available." And the plan states: "There are major gaps in: manpower resources; utilization of services; costs and expenditures for care; and data for areas below the national level needed for planning, managing and evaluating programs." Several specific initiatives are identified but overall, ". . . the strategy is to accelerate the implementation of the Health Statistics System to provide comparable data at the national, state, and local levels on vital events, health manpower, health facilities, and utilization of health care. This effort is especially important to meet the data needs of the new health systems agencies established under the National Health Planning and Resources Development Act of 1974 (P.L. 93-641), the PSRO's, the national health insurance program, other expanding health programs, and researchers and health system managers in the private sector.

The above underscore my point that we are confronted by the challenge to produce evidence that mental health services are effective and efficient in order to get adequate resources to provide mental health services to meet the needs of all. This argument has a seductive appeal for governmental leaders and managers, but it is not entirely realistic. And it is certainly unreasonable to impose excessive demands for proof on mental health services.

Medicare is a good example of the way in which a discriminatory approach has been taken toward mental health benefits. I have testified repeatedly as a spokesman for the APA urging that outpatient benefits be extended and that the lifetime limit on hospital benefits be eliminated—but to no avail.

The inclusion of coverage for renal dialysis and kidney transplants, as well as other benefits for those with kidney disease, stand in sharp contrast. With virtually no challenge, coverage that will soon reach a cost of a billion dollars annually was provided for those with kidney disease—perhaps 50,000 persons. Unquestionably they are deserving of care, but it surely seems that if we can put such a large amount of funds into a program that for the most part improves the quality of dying, we can fund mental health programs to improve the quality of living.

As already indicated, I support evaluation but this should be built into all health legislation in such a way that the progress of programs can be monitored and adjustments can be made to increase effectiveness. If over time they do not contribute to health, then limitations can be imposed. In other words, we must not wait for absolute proof before covering mental health services. Actually, the inclusion of coverage offers the best opportunities for evaluation. It also gives us the best chance of determining whether good mental health services reduce the utilization of general medical and surgical services, as many studies suggest.

Evaluation? Yes! Quality control? Certainly! But let's have them on an ongoing basis, as parts of the process of care, not as an obstacle or justification for cost saving cutbacks.

In closing, let me return to the needs of the Spanish speaking populations of the United States. If real progress is to be made, we must look to Spanish speaking psychiatrists for guidance and leadership. There are approximately 750 Spanish speaking psychiatrists within the APA. These members are an enormous resource. It is estimated that there may be about 375 Spanish speaking psychiatrists who are not members of the APA. Some may have problems as foreign medical graduates in qualifying for licensure; many do not—we need them in the APA.

It has been gratifying to see the progress that has been made: (1) the APA Task Force on Spanish Speaking People has now become the Committee of Spanish Speaking Psychiatrists; (2) Spanish speaking psychiatrists have accepted appointments to many key committees and councils, including Victor Bernal (Chairman, Council on International Affairs), Pedro Ruiz (Membership, Advisory Committee on Minority Fellowships), George Adams (Program), Ramon Fernandez-Marina (Task Force on Liaison with International and Foreign Psychiatric Organizations), Alfonso Paredes (Graduate Education), and Cervando Martinez (Public Affairs); (3) the publication of a newsletter is facilitating communication among Spanish speaking psychiatrists, which should help to increase membership in the APA and increase participation of those who are already members; and (4) this conference itself, with its theme – Psychiatric Services to Spanish Speaking Populations in the United States – will help increase awareness.

Speaking for myself, I know that until recent years I lacked awareness and sensitivity to the special problems and needs of the 19 million Spanish speaking persons in the United States. Thanks to Spanish speaking psychiatrists, I am becoming more sensitive to the needs of the Spanish speaking people.

Finally, I will stress again, evaluation and quality control are not ends in themselves. They are prerequisites, the necessary tools needed to assure that adequate health resources will be made available so that we may achieve the goal of adequate and accessible mental health services for all persons.

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THE COMMUNITY MENTAL HEALTH CENTER IN THE CENTRAL CITY: ISSUES FOR THE ADMINISTRATOR

Alfred Freedman

Since the launching of the program in 1963, the community mental health centers in the United States encountering the most difficulty have been those in the central city. While the percentage of failure in the central city has been higher than that outside the city, all have not failed.

One of the major problems encountered by community mental health centers in the central city has been dealing with the minority populations inhabiting the catchment area. It is clear that those in charge of the community mental health centers—the administrators and the directors—too often are ill-prepared to deal with the population they are serving. Frequently those in charge of the community mental health center are of different ethnic backgrounds than the population served. However, having individuals of the same ethnic group as directors has not necessarily guaranteed success, even though such individuals may at first receive greater sympathy and tolerance from the population. For all, adequate training is necessary to develop the knowledge, skills, and attitudes that are prerequisites for dealing with the very difficult problems of an inner city population.

What advice can one offer to the leadership of a community mental health center for dealing with a central city population, while remaining committed to excellence in mental health care delivery? The community mental health center director must have great respect for the individuals who inhabit the catchment area. It must be a true regard and not merely acceptance or condescension. Differences of ethnicity, class, education, or experience must not blind the director to the strengths, unique knowledge and experience, as well as the abilities of the citizens inhabiting the area. Having recognized these strengths, the director will then be willing to work with others from the community, either through community organizations or individuals in the community. Too often the staff decides to go into business for itself by setting up storefronts in the name of the community mental health center. Well intentioned, and often with missionary zeal, the staff at such installations ignore an already high order of existing community organizations—fraternal, social, political and religious. The analogy to the missionary is appropriate, since frequently the approach is that of bringing the "true word" from afar to those who are ignorant of the best way to do things. One must learn to share leadership, accept the leadership of community groups, or provide leadership in a joint enterprise, determining the best role appropriate for each situation and issue. Too often the professional staff alone determines program goals and priorities without considering the aspirations and sensitivities of the community, as well as the necessity of involving them in the planning process from its inception. It may turn out that the goals sought differ markedly from those considered most desirable by the profession. Progress must be achieved through collaboration, through brokerage and through negotiation. The days of confrontation politics are over. Desire for negotiation and meaningful social progress is greater now, since experience has shown that simple solutions supported only by rhetoric do not present lasting results. One must take advantage of all opportunities to work together in mutual respect.

In the work of the New York Medical College Department of Psychiatry in East Harlem, we have found one of the best areas of such partnership has been that of housing. By joining together with neighborhood groups interested in rehabilitating existing housing or building new housing, as well as joining together with the populations of existing public housing, we have found many opportunities for developing significant mental health programs.

The high priority given by community citizens to health matters, and particularly mental health, has surprised many. Very high concern is manifested for the mental health of children and of the aged. Managers, as well as individuals living in the housing projects, have been trained and mental health stations have been set up in relation to housing units. These mental health stations have been staffed by the residents of the housing project with consultation and backup by the community mental health center.

This emphasizes the necessity to pay heed to the diverse interests of those who surround the center. The socially responsible mental health director cannot afford to shrink from the task at hand by saying, "It is not my problem." The director and staff do not have to become organizers and developers of housing projects. However, they must be able to join together with community groups to develop better housing or improve existing housing as a concomitant of improving the delivery of mental health services. The director must be committed to join together with community groups to develop better housing or improve existing housing as a concomitant of improving the delivery of mental health services. The director must be committed to join together with the residents through example, education, and participation in the development of priorities and programs. Roles must be clarified and responsibilities delineated. The director of a community mental health center also will need great skill in dealing with the staff of the center.

One of the most difficult areas is the reconciliation between apparent inside needs of the center with outside pressures and needs. Often, this manifests itself in the conflict between training and service. Thus, those responsible for service may feel training needs and the time required are an intrusion or an obstacle to providing better services. Those responsible for training will emphasize the need to develop larger numbers of professionals and nonprofessionals to serve the steadily mounting needs of the community. Likewise, community people may look upon training programs as a "ripoff" and waste of their tax funds. This attitude may also be prevalent in myopic bureaucrats who are more concerned with cost-benefit and the balance sheet than with provision of services currently or in the future. For area residents, constant education and sharing of information is necessary in order to delineate the objectives of a training program, as well as the constraints. If training programs involve not only professionals, but also the training of mental health workers from the immediate neighborhood, goals and aspirations can be better communicated and accepted.

Agreement on goals between community mental health center staff and community residents is all important. Too much time is spent in crisis management without ever delineating at least middle-range goals. By collaborating one must determine what can be achieved, the resources available, and then, guided by experience and research, develop a strategy most likely to achieve those goals. One must never promise more than one can deliver. In joining together for mutually determined objectives, it is necessary to weigh the limitations, obstacles, and circumstances that may hinder or prevent the achievement of set goals. The realities of funding must be shared. Somehow the sense of being in things together, with the possibility of losing sometime and winning sometime, is mutually accepted. The notion that one may have to compromise between what is ideal and what is feasible must be agreed upon. This does not mean that one must always try to act in a safe and sure fashion. Innovation must be encouraged and this means taking risks, risks in sharing authority, such as turning leadership over to those community organizations which have not exercised leadership in mental health before.

One must be prepared to use many modalities and synthesize many variables in solving problems. The field of psychiatry is too often characterized by those whose thinking has become polarized around a single modality, whether it be psychopharmacology or psychoanalysis.

There is great necessity for continual evaluation and monitoring of programs for their effectiveness in meeting the social needs of the community. This is one of the most important roles the staff of the community mental health center can carry out. In this regard they must, first of all, consider access: Which consumers are able to get which services and who gets left out? Second, quality of services must be evaluated: How good or bad are the services that are delivered as measured by which standards and with what differentials among population groups at risk? The third is financial: Who pays how much for services and by what arrangements? What happens to level of cost in the health sector as compared to other sectors of the economy?

It is apparent that a key role in community mental health centers is in the hands of the director of the center who must have a high degree of managerial competence. Directing such a center, particularly in the central city, is an arduous task. Given the problems often encountered, one might conclude that the best training would be in law or in finance. However, one should not conclude that the best administrator in a mental health situation would be a lawyer, an accountant, or a person exclusively trained in administration. The great need is for individuals with experience in the mental health field—psychiatrists, psychologists, and social workers—to enter the field of administration and assume leadership. With this background they will be exquisitely sensitive to the needs of the community served. This is of utmost importance in the central city when one is dealing with minority populations. Likewise, the director must be keenly aware of the aspirations and needs of the staff of the center and set programs and goals that the community and the staff can join together in achieving.

It is essential to keep in the foreground the purpose for which the facility was established and those whom it is to serve. The primary purpose of the facility—treating citizens in distress—must never be forgotten. If there is true commitment to the community, the success of the center will be assured.

CLINICAL ISSUES IN THE PSYCHIATRIC TREATMENT OF PUERTO RICANS

Vicente Abad

Juan Ramos **Elizabeth Boyce**

In areas on the mainland where there are Spanish speaking communities, there is an increasing need for mental health programs to respond effectively to that population. As their marginality decreases with increasing political power, more attention may be given the demands of Puerto Rican leaders for relevancy in community services. A number of writers have pointed out the importance of recognizing the language and culture of Hispanics in service delivery, emphasizing hiring bilingual-bicultural staff (Abad, Ramos and Boyce, 1974; Padilla and Ruiz, 1973; Philippus, 1971). Yet, even under ideal conditions when administrators are willing to modify programs and allocate adequate staffing resources, the Hispanic patient may still be a puzzlement, baffling to diagnose and treat, and a challenge to the theories and methods acquired in most clinical training programs. The intention of this paper is to identify those clinical issues which, if not always unique to Puerto Ricans, are frequently seen among Puerto Rican patients at psychiatric clinics. In doing so, the authors share some of their clinical impressions of the Puerto Rican psychiatric patient.

Some Background

For the past four years, the authors have been affiliated with a psychiatric service devoted exclusively to the Hispanic population of Greater New Haven—the Spanish Clinic, or Clinica Hispana—at the Connecticut Mental Health Center. The host institution is a comprehensive mental health facility sponsored jointly by the Yale University Department of Psychiatry and the Connecticut State Department of Mental Health. Since comments stem in large part from impressions gathered in the Spanish Clinic, it is well to look at some data on the population being served.

The Hispanic population of New Haven, mostly Puerto Rican, numbers approximately 15,000 people. The majority of adults attending the Clinic are of lower socioeconomic status, inadequately housed, poorly educated, unskilled and often unemployed. They reside in ghetto neighborhoods where isolation from the Anglo community reinforces ethnic cohesion. Families are large and frequently splintered through migration or as a result of pressures found on the mainland that contribute to separation. They share with California Mexican Americans some of the predictor variables correlated with mental breakdown, as shown in studies by Karno and Edgerton (1971) and Torrey (1969): poor communication skills in English; the poverty cycle, i.e., limited education, lower income, depressed social status, deteriorated housing, and minimal political influence; the survival traits from a rural agrarian culture which are relatively ineffectual in an urban technological society; and the problem of acculturation to a society which appears prejudicial, hostile, and rejecting.

Our discussion, therefore, is pertinent to Puerto Rican patients from the lower socioeconomic class. Middle and upper class Puerto Ricans share many cultural traits, beliefs and values with Puerto Ricans in poverty. However, education and other opportunities of a higher social status have given them more alternatives and resources for coping with stress.

Common Clinical Problems

Hundreds of contacts with our patients have revealed such a repetition of symptoms, life situations and experiences, that upon an initial interview with a patient, one is struck with the familiarity of a theme heard many times before. We do not suggest a lack of individuation among patients, but rather a similarity in clinical material that is useful in building one's understanding of the Puerto Rican patient.

Puerto Rican patients present with an unusually high degree of somatic complaints. Statistics from the emergency room at Yale-New Haven Hospital reveal an exceptionally low number of Puerto Ricans being treated as psychiatric emergencies compared with those referred for medical treatment based upon their presenting complaint.

While Puerto Rican patients insist upon the legitimacy of the headaches, dizziness, muscular aches, chest pains and palpitations about which they complain, they also have a sense that their symptoms would be relieved if they could only control their "nerves." For example, one of the most common complaints of physical distress is the *dolor de cerebro* (i.e., "brain ache") which they locate in the occipital and upper cervical areas. Whereas other possible physical conditions, such as cervical spondylitis might be involved, the *dolor* is probably equivalent to the "tension headache" of Anglo patients. The approach to somatization found most useful by clinicians at the Spanish Clinic is one that accepts and seeks to relieve the bodily complaint of the patient and, in that process, gains the confidence of the patient, which allows exploration of underlying problems.

Seen almost as frequently as patients with somatic complaints are patients who are non-psychotic, yet describe hallucinatory experiences which we will refer to as pseudo-hallucinations. Compared with hallucinations of a psychotic patient, pseudo-hallucinations generally tend to be less dramatic and often occur just prior to falling asleep at night. In general, they are less disturbing psychologically and more culturally syntonic than hallucinations of the psychotic. Their onset is frequently precipitated by situational stress of a transitory nature and typically includes visual imaginings or auditory sensations of hearing one's name being called, knocking at the door, or strange noises about the house. Voices or visions of people recently deceased are not uncommon.

Pseudo-hallucinations suggest a link to religious beliefs and the supernatural. While often disturbing to the patient's equilibrium, they may also contribute to a sense of well-being. Some form of communication from a loved one departed may be both welcomed and expected as family and friends gather after a funeral. The longing of a patient was depicted in his description of being transported by spirits to Puerto Rico each night, to be returned the following morning. An elderly patient appeared to be preparing for his own death as he talked about repeated transportation to an ethereal heaven where he met old friends and relatives.

Pseudo-hallucinations may disrupt only temporarily an individual's stability. Unfortunately, they can be overdiagnosed and result in unnecessary hospitalizations. At such times, the barriers of language and culture between Anglo clinician and Puerto Rican patient are critically apparent.

Although epidemiological data is still inadequate, available studies point to a high incidence of schizophrenia among Puerto Ricans, both on the island and on the mainland, a finding perhaps not too surprising since psychotic disorders are more prevalent among the poor than other socioeconomic classes (Green, 1960). Recent statistics show that the median income for Puerto Rican families is the lowest of all ethnic groups in the United States.

Whereas Rogler and Hollingshead's (1965) research revealed no significant social or cultural differences between parental families, or even life experiences between schizophrenics and non-schizophrenics, others have explained the high incidence of schizophrenia and mental illness as related to a composite of certain cultural traits, social conditions, migration, prejudice, language barriers and misdiagnosis.

Fitzpatrick (1971) reviewed studies which examined Puerto Rican culture as it relates to mental illness, and concluded that certain childrearing practices in Puerto Rico may foster tensions and conflicts in adult life: the emphasis of submissiveness among females, the stress on *machismo* among males, a close dependency between mother and son, the emphasis of power in relationships which may result in subsequent resentment of authority figures, and an emphasis on respect with an exaggerated sensitivity to offense, with a resulting potential for physical retaliation. During the formative years of childhood, poverty adds immeasurably to the stresses felt within the family.

The possible effect of migration upon the incidence of mental illness suggests a number of possibilities. Some authors have claimed the disruptions of the migration experience are directly related to mental breakdown in vulnerable individuals, whereas others have proposed that migration may be particularly attractive to individuals who already suffer from emotional disorders and seek in migration a relief of their distress (Fitzpatrick, 1971; Murphy, 1955). It should also be noted that the migrant population may indirectly bias figures on schizophrenia since most migrants are relatively young and schizophrenia is an illness of the young. Although not controlled with the normal Puerto Rican population, our observations in the Clinic support the view that psychiatric patients are particularly mobile, frequently changing their local address and moving back and forth between mainland and island.

Language and prejudice have clearly influenced the labeling of psychopathology and service delivery to Puerto Ricans. We are aware of problems encountered by Anglo psychiatrists and other clinicians in attempting to assess a patient with whom they cannot communicate directly. At times, there can be an overestimation of pathology, as when there has been an episode of discontrol or the patient appears histrionic. In other situations, such as cases of mild thought disorder or skillfully concealed paranoia, pathology has been underestimated. Of great concern is the possibility of Puerto Rican patients becoming hospitalized for psychiatric illnesses which they may not have.

Problems of impaired impulse control, implicit with the potential for harming self or others, are a concern of many of our adult patients. This problem seems to increase at times of hormonal change such as puberty, premenstrual and post-partum periods and the onset of menopause. Overwhelmed mothers express fears of losing control with their children and, at times, children may be punished harshly when the mother is under mental distress. Functioning is disrupted by threats or acts of retaliatory behavior toward person or property. Such unpredictable behavior is as destructive emotionally to the individual committing the act as to a person living in fear of attack. In part, a contributing factor to the explosiveness of many patients is the excessive suppression of anger and verbal aggression inculcated in Puerto Ricans through childrearing practices.

The high rate of suicide attempts among Puerto Ricans is borne out by studies at Bellevue and Lincoln hospitals in New York City (Marmor, 1954; Trautman, 1961) as well as statistics from the Yale-New Haven Hospital where suicide attempts account for the majority of psychiatric emergency admissions. Terming the suicide pattern among Puerto Rican patients "the suicidal fit," Trautman describes a typical episode as ". . . an act in which a person, in a state of intense emotional excitement, suddenly runs from the scene to another room, snatches whatever poison is at hand and swallows it. The whole episode in many cases is brought on by an angry verbal argument. . . . These swallowers of poison were highly emotionaly and had usually suffered from emotional stress with recurrent crises for quite some time before the suicide attempt."

Clinicians are continually impressed by the quickness by which outwardly hostile impulses, unable to find expression, can suddenly turn inwardly, and result in a suicide attempt. Assessment of suicidal and homicidal risk requires careful evaluation. Alcohol often plays a significant role in precipitating homicidal-suicidal behavior. In our opinion, minor tranquilizers can have a paradoxical effect with such patients and should be prescribed with caution. In cases where suicidal behavior is present in a patient with underlying depression and faulty impulse control, the combination of amitryptiline and perphenazine can often be helpful.

Although the Spanish Clinic is about to embark on a recently funded program for the Spanish speaking alcoholic patient, our experience with alcoholism to date is limited. History taking of our patients, however, indicates that it is widespread on the island and on the mainland. We have seen its deleterious effect on our patients and their families.

Data collected from the New Haven Police Department in 1971 indicate that Puerto Ricans are underrepresented in arrests for public intoxication compared with populations of blacks and whites. This probably occurs because of the protectiveness of the family toward an alcohol abuser whom they tolerate and shield. We anticipate that identifying oneself as an alcoholic who needs help will be a difficult admission for the *macho,* Puerto Rican male.

A successful alcoholism program for Puerto Ricans calls for vigorous case finding with cooperation from families, employers, clergymen, etc., who are able to put pressure on the alcoholic to help motivate him to seek help. Within the context of *machismo*, it can be emphasized that it is manly to control the alcohol problem and not vice versa.

Finally, the Puerto Rican *ataque* is a familiar reaction often precipitated by poorly repressed anger after a family discord. Often misdiagnosed, the *ataque* is a hyperkinetic episode, including a display of histrionics or aggression on the part of the patient, and sometimes culminating in a stupor. It is critical for clinicians to be able to differentiate an *ataque* from an epileptic seizure or other pathology.

A former patient who was subject both to epilepsy and *ataques* reported that, during the epileptic seizure, he lost consciousness, sometimes bit his tongue, became incontinent and felt sleepy and amnesic after the episode. In the case of the *ataque*, a prior emotional upset would usually elicit it. He would become agitated, would cry, and would feel like running away. After walking aimlessly about the streets, he would end up at a friend's home or a bar, kicking the furniture, flinging himself about, and possibly fainting at the end. Though *ataque* patients may sometimes claim so, as a rule, they are not amnesic and, upon closer interrogation, can usually remember what took place. There are obvious manipulative features and secondary gains from an *ataque* since the patient can express his hostility without others holding him responsible for his behavior, and he usually manages to mobilize friends and relatives to his aid.

In cases of temporal lobe epilepsy, distinction becomes more blurred. However, as a rule, the *ataque* behavior is more complex, charged with greater affect, and usually provoked by frustrating events.

Other Clinical Issues

Many of our patients, especially those with the fewest social resources, present with a multiplicity of problems, and often appear helpless and dependent. They turn to the clinician for solutions to extensive personal entanglements, redtape complications of social systems, or extreme misfortunes dealt them by life. Responses by clinicians feeling overwhelmed and impotent in their ability to help, or misguided by fantasies of omnipotence, can vary from oversolicitousness to anger and rejection. Cognizant of the relationship between social conditions and psychosocial functioning, we do not hesitate to assume an advocacy role in behalf of patients. Helping patients with tangible, socioeconomic problems can be an entry into treatment at a psychological level. However, social and economic pressures transmitted to the therapist by the patient should not obscure the need for psychological intervention.

The issue of the use of paraprofessionals has become one that almost implicitly enters into any discussion on mental health and minorities. For Puerto Ricans, the indigenous paraprofessional has opened doors to services otherwise denied them by virtue of language and culture barriers. Our concern is that paraprofessionals receive adequate training and ongoing supervision for their assignments and that they be complemented by bilingual-bicultural, professional staff. We are aware that the scarcity of professional staff qualified to work with Spanish speaking patients can easily result in the abuse of paraprofessionals through assignment to them of excessive clinical responsibilities.

The dilemma of possible overburdening of our paraprofessionals reflects the failure of training programs to prepare Anglo clinicians with the ability to work with Spanish speaking patients. We have had the opportunity to test two different models for using paraprofessional staff in mental health services. In one model, after a period of inservice clinical training, paraprofessionals are given the responsibility for primary patient care. They receive professional support and supervision, but they are the "therapists." In the second model, only the professional staff have responsibility for patient treatment. Professionals are assisted by paraprofessionals, mostly in the area of dealing with community resources. There are advantages and disadvantages in both cases. In the first model, bilingual-bicultural staff are used more fully, but therein lies the danger of their being abused when given professional responsibilities without adequate training or support. In the second model, the professionals and paraprofessionals try to meet all aspects of patient care through a team approach. The cost of this model is higher, and it also maintains a rigid role definition for paraprofessionals.

A striking commonality found in the course of taking a history on our patients is that of early life deprivations and loss. We encounter numerous examples of women who sought escape from the harshness of their lives as children by entering into early sexual relationships with men who later deserted them. Adult life, including migration and experiences on the mainland, often perpetuates the deprivation that is clinically manifested in patients who reveal depression, low self-esteem, sense of distrust, difficulty maintaining longterm relationships, and craving of oral needs. The prevalence of consensual unions facilitates impermanency of commitments between men and women, in turn affecting family stability and creating situations of parental deprivation for children. Nurturance in childrearing patterns is often inconsistent.

Oral needs may be alternately deprived and gratified excessively. In addition, parents tend to foster dependency and strong oedipal ties with their children. Such practices are known to potentially result in the development of oral and hysterical personalities (Malzberg, 1956). Extensive studies by Wolf (1952) and Green (1960) describe in detail the patterns of childrearing and other cultural influences on behavior and are helpful resources for clinicians looking to better understand possible etiological configurations in the behavior of Puerto Rican patients.

Stereotyping of patients should be avoided. Patients present themselves at different levels of ego development and with a range of requests and expectations. Many patients prefer intermittent contacts over an extended period of time with easy access to services at times of crisis. To insure flexibility and responsivity in our service, it was initially designed as a "walk-in" clinic. However, we soon realized that emphasizing "walk-in" visits did not encourage longer-term therapeutic relationships. Our clinic has evolved to seeing patients on a regular appointment basis while maintaining flexibility in crisis situations. Rather than any particular treatment approach, it is our opinion that the personal qualities and special skills of the therapist will determine the success of treatment.

The importance of *espiritismo* as a source of help and support for the mentally ill has been emphasized by many authors. Attending an *espiritismo* center does not carry with it the stigma of receiving psychiatric treatment. Certain authors have recommended including indigenous folk healers in mental health programs (Garrison, in press; Ruiz and Langrod, 1962; Torrey, 1969). The Lincoln Community Mental Health Center in the South Bronx is having a positive experience with folk healers and utilizes them directly in their treatment program. Ruiz and Langrod (1962) reported that mental health professionals, observing the practice of *espiritismo,* were impressed with, ". . . a built-in 'caretaker' system, capable of translating stressful events and deviant behavior into acceptable explanations for their occurrence and offering specific remedies for coping with them [and] . . . therapeutic value of a set of beliefs that provided social support for persons undergoing emotional disturbance." These investigators have developed inservice training to familiarize their staff and folk healers with each other's practice and propose training folk healers as a means of incorporating them as assistant therapists in mental health centers.

Open collaboration between folk healers and mental health professionals remains controversial. The subject provokes heated discussion for and against its merits among Puerto Ricans. Decisions whether to involve *espiritistas* in mental health programs will be dependent upon the prevailing climate of the individual Hispanic community and the psychiatric setting. Degree of receptivity may vary between communities. Our own reservations stem from the ambivalent attitudes of some Puerto Ricans toward *espiritismo;* concern that individuals strongly involved in a religious faith may feel offended by an official endorsement of *espiritismo;* and the preference of many patients attending *centros* to keep their visits a private matter. Research is needed to clarify those circumstances where folk healers might be most effective and where they would be less so, or even contraindicated.

Concluding Remarks

There remains a challenge to community mental health centers in the 70's to insure relevancy of their programs to target populations that are ethnically and culturally diverse. Clinical training programs should give a higher priority to the study of social and cultural factors in mental illness, to the development of cultural awareness, and to principles of cross-cultural therapy. Cross-class and cross-cultural misunderstandings between ethnic minority patients and mental health professionals will otherwise continue to impede effective service delivery.

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A COMMUNITY MENTAL HEALTH PROGRAM FOR THE SPANISH SPEAKING POPULATION IN CHICAGO: EIGHT YEARS OF EVOLUTION

Moises Gaviria **Albert Vazquez**

Pablo Holguin **Mary Gentile** **John Tirado**

Under the aegis of the war against poverty of the 60's and the Community Mental Health Movement, mental health services became accessible for the first time to minorities in this country.

After the Black population, persons of Spanish speaking origin form the largest minority group in this country, with 9.6 million people (U.S. Census of Population, 1970), or roughly 5% of the total population. The four major Spanish speaking groups are the Mexican Americans or "Chicanos," the Puerto Ricans, the Cubans and large groups of Central and South Americans. Of these groups, the Mexican Americans are the largest in number, with 5.5 million people* (U.S. Census of Population, 1970), largely disseminated across the southwestern states.

In the city of Chicago, according to the 1970 U.S. Census, the Spanish speaking population was 247,343 which represents 7.3% of the city's total population *(Chicago's Spanish Speaking Population, Selected Statistics,* 1973).

The unique linguistic, social and cultural characteristics of the Spanish speaking population make the design of mental health services a difficult task, requiring new models to be developed and evaluated if services are to be relevant. There have, of course, been previous experimental mental health programs, which have marshalled community resources to relieve social stresses and effect institutional change (Ruiz and Behrens, 1973). Many have used bilingual staff, walk-in clinics, educational and preventive programs (Abad, Ramos and Boyce, 1974), and indigenous nonprofessionals both as mental health workers (Reiff and Riessman, 1965) and as social change agents (Schensul, 1974). Currently, the implementation of a general systems model based on the recent concepts of an "egocentric social network" (Bott, 1957) is also being utilized in one project at the University of Miami, Department of Psychiatry (Weidman, 1973; Weidman and England, 1973; Lefley,

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*Editors' note: These figures are disputed by many (e.g., U.S. Commission of Civil Rights, 1974), and are seen as gross underestimates of the actual number of Mexican Americans.

1975). Nevertheless, a comparative evaluation of the different theoretical models as well as their implementation and effectiveness is yet to be done.

The authors present the developmental history of a community mental health program in Chicago, Illinois between 1967 and 1975. Over this eight year period changes in the political climate, community awareness, federal support, institutional control and ethnic distribution brought about a metamorphosis of a program emphasizing training and research, into a community program serving primarily a large population of Latino residents.

Developmental History of the Program

The Community Mental Health Program at the Westside Medical Center in Chicago began its eight year cycle of funding in September, 1967. This grant was designed and submitted by a task force of personnel from the various university and state mental health institutions at the Medical Center. The grant linked inpatient and specialized psychiatric services at the Medical Center with outpatient clinic "outposts" located in each of the three major communities in the catchment area (Freed and Miller, 1971).

The catchment area of the community mental health program was located adjacent to the Medical Center and covered an area approximately 10 square miles on the west side of Chicago. The population of 150,000 was comprised of Latinos (primarily Mexicans, 50 percent), Middle Europeans (primarily of Polish and Czechoslovakian descent, 30 percent) and Blacks (20 percent).

The goals of the program as taken from the original proposal were to provide services for three communities in the catchment area, to encourage community participation of residents in the events and decisions of the program and to facilitate community organization and other activities which can prevent mental illness. The provision of culturally relevant care to the non-white, non-middle class residents of the catchment area was strongly related to the assumption that social and cultural factors played a key role in the childrearing process and in adult personality functioning. The original proposal stated that community organization should be aimed at the mobilization of the "community to serve as a positive psychiatric resource and as a support system for effective social functioning and mental health (Freed and Miller, 1971)."

Structure and Components

The Community Mental Health Program, like many institution-based programs, was divided into two primary programs. One component consisted of inpatient and specialized services located in the Medical Center while the other component consisted of three outpatient, outpost clinics which provided the heart of the community outreach of psychiatric services. The inpatient unit of the program was set up in a separate ward of a psychiatric institute devoted to training. Before the inception of the Community Mental Health Program few catchment area residents had access to these psychiatric services.

The community-based portion of the program was initially planned to include five outpost clinics, each staffed by full psychiatric teams of psychiatrists, psychologists, psychiatric social workers, other mental health professionals, and a few paraprofessional community workers. The outposts would be located in the Black community, in the primarily Mexican community located in the east, and in the Middle European-Latino community located in the western portion of the area. The overall program was to be under the Community Mental Health Program director whose central offices would include administrative personnel and a research evaluation section.

The program began with the opening of the outpost clinic in the 18th Street Mexican community in December, 1967, and was immediately beset by problems. The staff, comprised mainly of Anglo females, soon discovered their limitations in dealing with residents with whom they could not communicate and who shared few of their concepts concerning health or psychiatric services. Rather than initiate efforts to develop new and culturally relevant therapeutic programs, the staff of this outpost retreated from their community orientiation and stayed with traditional psychotherapeutic techniques. Coinciding with the opening of the clinic, inpatients from the state mental institutions and patients from the Medical Center training institutes were transferred to this new community facility. As a result, while little communication was being established with the Mexican community, the Community Mental Health Program staff became busy providing psychiatric services to a chronically ill Middle European population of recently discharged patients. While others in the program sought links to this newly developed Chicano community, the outpost staff in this early period remained isolated from community contacts and underutilized by community residents.

Subcontracts for Service

Early in 1968 a clinical outpost was established in the Westside Black community. The outpost was staffed by some Anglo social workers from the original 18th Street outpost and several part-time Black therapists who were drawn from other social service agencies in the city.

This outpost was established at a time when two Black community organizations on the Westside were beginning to voice their criticism of health and other societal institutions, and to demand participation and control over human service resources in their community. Shortly after the Black community outpost was established, these two community organizations confronted the program administration with demands for an all Black staff and control over the funds and direction of the programs in their two segments of the near Westside Black community (Ellis, 1969; Keniston, 1968). They felt the staff of the Community Mental Health Program did not have the necessary experience to treat the residents in their area. They demanded that local people be hired as staff members to deal with the problems of alcoholism and drug addiction. Negotiations between program administration and leaders of these two community organizations were filled with tension, confrontational rhetoric and physical threats. By late spring of 1968, the Community Mental Health Program moved to resolve this confrontation by developing a sub-contractual relationship in which the two Black organizations would receive yearly stipends to provide mental health services. This subcontractual relationship was maintained throughout the rest of the program with one of these organizations, while the other dropped out of the mental health business after the third contractual year. Thus, unlike the 18th Street outpost and the one that would be set up in the Middle European-Latino community of 26th Street, the Black outposts established an independence both administratively and structurally from the rest of the program (Freed, 1972).

To complete the original design of the Community Mental Health Program, the last outpost was established in 1969 in the predominantly Middle European, but increasingly Latino, community on 26th Street in the western section of the catchment area. Several of the social workers from the 18th Street outpost were transferred to this new facility, while other mental health professionals were added to the staff. This outpost soon began to confront the very same problems that faced the 18th Street outpost. However, in the case of 26th Street, even greater ethnic diversity made many of these problems more serious. Dispensing of medication and the aftercare of patients became the primary activities for the center.

The program was beset by a range of problems in these early years which related not only to the community outposts, but to the overall structure and organization of the program. The various cooperating institutions in the Medical Center had identified portions of their own programs which coincided with service goals of the Community Mental Health Program. However, the director of the Community Mental Health Program never had line-staff responsibility over these components, since they remained under the direction of the particular institute's administration. As a result, the Community Mental Health Program director had budgetary and supervisory responsibility over the outpost staff and a small core of central administrative and research staff only. Program-wide policy could therefore not be established by directive; negotiations with, and the consensus of other mental health institutions were mandatory. As a consequence, inpatient services, specialized units and each of the Community Mental Health Program segments began moving in separate directions.

Applied Research and Community Development

In December of 1968, a research component was established. This unit, composed primarily of anthropologists, was to collect information on cultural and community dynamics of the catchment area which would help the program develop new treatment modalities and structure preventative activities (Schensul, 1972). However, the research unit found that the program staff was not particularly interested in such information since they did not see it as providing assistance in day-to-day service activities. The research staff then began establishing themselves as a research facility for the community. They provided information helpful in the development of new resources in the community. Several of the Latino staff from the outposts, in collaboration with members of the research unit, became intimately involved in community action and development in early 1971. As a result of this collaboration, an informal "preventative arm" was established in the program. Members of the research unit and the outpost staff who were less directly involved with patient care began to participate in community meetings, develop information-gathering projects to support community positions and grant proposals, help in the planning and establishment of indigenously-controlled programs and act as advocates for the community in various institutional and social agency settings. These efforts, linked with the increasing effectiveness and activism of Chicano community groups, resulted in the establishment of a range of community-run programs and a significant increase in community power (Schensul, 1975).

In 1973, the first test of the viability of the outposts making up the present structure took place. It was at this time that the federal government made accountability a major concern. Pressure (the possibility of discontinuing federal funds) was applied by the government to form a monitoring board to centralize planning.

In response to these warnings, a management board was created in August of 1973. This board consisted of 17 members with voting rights; nine of these 17 members (three from each of the community areas) were selected by local advisory boards or temporarily appointed by the outpost chiefs. The remaining members of the board were drawn from the institutions at the Medical Center.

The Last Year of Federal Funds

The Community Mental Health Program management board met on a monthly basis from 1973 through 1974. Throughout this planning stage the council dealt most significantly with the diversity of concerns, biases and levels of organization present in their respective communities. A considerable amount of time was spent in dealing with issues of autonomy for the separate outposts and their respective advisory boards. Actual planning was, therefore, greatly impaired.

By this time the program had experienced a number of changes and continued to be plagued by a number of problems which it had experienced from its inception. The 18th Street outpost had a Chicano director and the majority of its staff were Latino. The 26th Street outpost also had a Chicano director and was trying to reorganize the goals and philosophy of the 26th Street outpost, which until then were irrelevant to the community to be served. The day treatment program, a new program supported by the university and placed under partial council control, was sharing the same uncertainty regarding funds for 1975. The research team which had provided the much needed technical assistance to various progams, and which had functioned as the "preventative arm" of the program, was losing key staff and was completely dissociated with the clinical segments of the program. Finally, the ethnic composition of the service area had changed, with the Mexican community making up almost 70 percent of the population.

In late 1974 the community members of the board joined together to plan for the spin-off year in which the Federal Government would discontinue funding, and in which the State Department of Mental Health (DMH) would assume financial responsibility. This group was able to get the National Institute of Mental Health (NIMH) to agree to turn over DMH monies that were being given to one of the institutions to operate a day hospital program.

One more problem existed. This board had to centralize administration and planning of services or DMH would not fund the program. Since this board was made up primarily of three different communities (two Latino and one Black) for which services were to be planned, centralized planning of services for these ethnically diverse populations appeared insurmountable. In addition, the Black members viewed themselves as a coalition group whereas the other two Latino groups viewed themselves involved in centralized planning. It was this issue that precipitated the dissolution of the board.

In May, 1975, the members of the two Latino Communities incorporated as the Pilsen-Little Village Community Mental Health Center, which was subsequently given a DMH grant to provide mental health services to this new service area.

The New Program

Presently the organization operates two outposts, the day treatment program and an administrative component. The two outposts are providing outpatient services, including short-term psychotherapy, crisis intervention, group therapy, family therapy and medication. They are responsible for the outpatient and aftercare aspects of treatment. Staff is composed primarily of paraprofessionals, with professionals in supervisory roles.

The day treatment program is seen as the second line of treatment, providing a therapeutic milieu in which clients improve their skills or learn new skills in community living. This program attempts to provide an alternative to full-time hospitalization for patients who cannot be managed on an outpatient basis.

The central direction of the service aspects of the program has come under the responsibility of a clinical director who works closely with the coordinators of each of the three clinical components of the program. The executive director, the clinical director and the coordinators of the three component programs work with the community board to plan the philosophy and the direction of the program. At present time, the program is three months in existence and attempts to reflect community concerns. The Board of Directors are representative of the community served and are growing in terms of understanding their role and responsibility to the community. While clinical services are centrally coordinated, problems still exist among the different components. Although treatment emphasis on aftercare follows the funding guidelines, the program is trying to reinstate the preventive arm and is seeking funds for a range of preventive programs which include: a mother-infant program, a program for senior citizens and child abuse and alcoholism programs. Health and mental health care services have already been merged in one health care center. The staff is mainly bilingual and the caseloads reflect the ethnic makeup of the community.

What is still lacking is a research component, not only in terms of program evaluation, but also in terms of a social science approach to community mental health. Linkage with the back-up institution, the integration of approximately 50 percent new staff, and the uncertainty of funding represent some of the current problems faced by the new program.

Conclusion

In reviewing the developmental history of this program, it seems that each stage took a particular philosophy and structure to its end point, setting up a new process and also leaving a legacy that was carried over to the next stage. Each phase contained contradictory aspects, producing tension, conflict and inevitable change.

The outcome of this eight year dialectic process included a change in the catchment area to be served, a movement from a hospital-centered program toward a community-centered program, a modification of the staff composition from Anglo professional toward Latino bilingual, paraprofessional and professional staff and from a nonexisting board toward a community board.

In developing mental health programs for Spanish speaking populations, a historical analysis of the different forces involved, their contradictions and tensions at each stage of the program, will be extremely helpful in redefining goals, shaping strategies and providing enough flexibility not only for the survival of the program, but for its further growth.

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PSYCHIATRIC SERVICES TO PUERTO RICAN PATIENTS IN THE BRONX

Harvey Bluestone **Beatrice Purdy**

The methods by which the needs of Spanish speaking patients who require mental health services from a hospital which has predominantly English speaking professional personnel will be described in this paper. The Bronx-Lebanon Hospital Center is responsible for the medical and psychiatric care of the residents of a community for whom almost no other services are available.

This community is characterized by the following: old, deteriorated housing with a constant influx of new residents, who are in the main young, poorly educated and have minimal job skills; the area is almost bereft of all cultural institutions and has minimal public and social services; there are few mail boxes on the streets, few banks, and the food stores have poor quality merchandise and higher prices than in other areas of the city; and there are few physicians, few lawyers, few accountants or other kinds of private professional businesses. However, despite this lack of services, the residents of the area are reluctant to leave their immediate neighborhood to seek these services. Many of our patients have never been to Manhattan. This is due to fear, ignorance and the high cost of public transportation.

The educational system is characterized by deteriorating and vandalized buildings, demoralized teachers, rapid staff turnover, a high rate of drop outs, absenteeism and truancy, and low levels of reading ability.

It is an area characterized by a high incidence of juvenile delinquency, venereal disease, out-of-wedlock births and infant mortality. The rate of juvenile delinquency per 1,000 youths in New York City in 1970 was 70.1; the rate of juvenile delinquency in the nine health areas that we serve went from 73.1 to 136.9 per 1,000 youths. The rate of venereal disease cases per 100,000 in New York City in 1970 was 447.9 cases. In the nine health areas that we serve, the rates ranged from 591.0 to 1,683.9 cases per 100,000. The rate of out-of-wedlock births for New York City in 1970 was 22.9. In the nine health areas that we serve, the out-of-wedlock percentage of live births ranged from 17.8 to 55.2. The rate of infant mortality in New York City in 1970 was 2.1 percent of all live births. In the nine health areas that we serve, the rates of infant mortality ranged from 1.5 to 3.6.

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The area is also characterized by a high incidence of assaults, muggings and murders. Residents are terrified to leave their homes. Fire is a common occurrence—whole blocks have been burned out. In general, the area looks like a bombed out European city after World War II.

The Department of Psychiatry of The Bronx-Lebanon Hospital Center has been in operation for 10 years. During that time a wide range of services has been developed including an outpatient clinic, a day hospital, an inpatient service, an alcoholism program, a court consultation service and training programs for medical students, psychiatric residents, social work students, nurses and paraprofessionals.

We have repeatedly had to answer the question for ourselves, our patients and students: How can a professional staff that is not only primarily English speaking, but predominantly middle-class American in culture, relate to and treat the Puerto Rican population for whom we are mandated to provide psychiatric services?

We wish to discuss in this paper factors we consider important to bring to the awareness of the "American" therapist who treats Puerto Rican patients. These include: (1) language and culture; (2) clinical phenomena; and (3) implications for patient care and staff training.

Language and Culture

We have studied in some detail the use of an interpreter/translator in diagnosis and treatment of Spanish speaking patients (Bluestone, Bisi and Katz, 1969). We recognize that difficulties in making a language adjustment can be connected with broader emotional problems of the individual which relate to phobic avoidance of the environment.

Due to the size of the Spanish speaking patient load and the smaller number of bilingual professionals, we recognize the need for interpreter/translators as an important answer to the language barrier. Recently, the availability of bilingual professionals, however, has lessened dependence upon untrained translators. These paraprofessionals have emerged not only as cotherapists, but as individual and group counselors.

Yet experience has shown us that priority must still be given to increasing the number of bilingual professionals with advanced degrees. We would rather be accused of being elitist than of maintaining that paraprofessionals can do all. The clinic patient should have the option of calling upon the expertise of the professionally trained and experienced clinician. Means to accomplish this do exist, for example, in the selection of psychiatric residents, in opening traditional job lines to qualified applicants holding advanced degrees in allied disciplines, and in informal and formal contacts with professional schools.

We have observed that avoidance of learning English by our patients suggested broader emotional problems related to phobic avoidance of the environment. We also recognize that, for some, holding on to Spanish is a means of retaining Puerto Rican culture and identity. Sociopolitical factors may be as influential as psychological factors.

Perhaps the "American" clinician who can best treat Puerto Rican patients is the one who finally realizes that the Puerto Rican culture is different—it is not "American"—and that it not only confounds him at times, but frustrates him in his practice and may even cause him to err in his diagnosis. If he can recognize that *he* has to learn, and wants to, then he will find his skills can be more appropriately applied. We would add that a clinical service itself must go through this process so that it can provide the clinician with the opportunity and the impetus to learn.

There are several cultural aspects that impinge on the delivery of services. First, is spiritism. We have reported on spiritism as we have experienced it at Bronx-Lebanon (Bluestone, Flores, Pullman and Purdy, 1972). We came to realize that many of our Puerto Rican patients either were currently, had been, or would be in "treatment" with spiritists as well as with us. We have realized that we must redefine the existing criteria of pathology with regard to some of our Puerto Rican patients as we will discuss later. We would also recommend that psychiatric clinicians collaborate with spiritists when feasible. This last suggestion does not appear to be so much a clinical problem as an administrative/philosophical problem. What we really have to handle is our own antipathy towards dealing with the occult or toward those who do deal with it.

Clinical Phenomena

Clinics delivering services to Puerto Rican patients must be aware of the nature of the *ataque* so that patients do not suffer a faulty diagnosis of epilepsy based on ignorance of what is witnessed or what is described by others. Also, being aware of the strong possibility of such an event allows the practitioner to handle the occurrence expeditiously, both for the patient's sake and for others who may be present and become upset—this is especially true in waiting rooms. In terms of family dynamics and treatment, the *ataque* has been seen to be an effective and aggressive defense against psychologically threatening material that may be presented by other family members, and a means of exercising control by producing guilt in others. This is a peculiarly female phenomenon.

Auditory hallucinations also take on, or perhaps lose, a certain significance when one is aware of spiritism. It is suggested that when the voices heard are those of the dead, or family members, friends or relatives, that the influence of spiritism be explored with the patient. More often than not, such hallucinations are not psychotic symptoms but are related to the patient's belief in spiritism. Most of us relate it to hysteria; some of us prefer to relate to it as a product of a cultural fact. In either case, the patient is protected from the misdiagnosis of schizophrenia.

The last factor we wish to discuss under clinical phenomena is that of the motivation for suicide in many of our Puerto Rican patients, particularly women. We have become increasingly aware of, and impressed by, the number of Puerto Rican patients admitted following suicide attempts who demonstrate no true depression. Rather, it is anger and frustration that has no acceptable outlet or means of resolution in terms of the environment or culture. Time and again the case history repeats the theme of mistreatment, real or exaggerated, at the hands of the husband, lover, or children. This is generally complicated by the theme of problems with welfare, housing, etc. A number of these patients become chronic suicidal risks in that they often make suicidal attempts in response to such pressures. Yet, when they recover from the overdose of unspecified pills—the common method—no evidence of depression can be obtained. Suicidal threats and/or gestures become the vehicle to convey this family member's message to others.

If we are correct in the above hypothesis, then increased involvement with the family would be the answer to repeated hospitalizations as the diagnosis would be family or marital discord rather than depression.

Implications for Patient Care and Staff Training

There are other implications for patient care inherent in the above discussion which do not necessarily relate directly to diagnosis and treatment. In the practice of spiritism, the medium generally labels the problem immediately, provides an acceptable explanation for it and gives the patient a concrete, action-oriented treatment plan.

We, in turn, should not hesitate to give advice and direction—patients usually come expecting this. Interest must be demonstrated concretely (a letter, a telephone call); these not only demonstrate interest, they relate in a real way to our patients' real problems.

Good clinicians never assume they understand a patient until they really do. Language barriers and cultural differences make this principal even more important. American therapists should know that they may well be vested with power and authority that they are not aware of. They may be expected to understand or comprehend factors that may not even have been revealed by the patient. This is based on the Puerto Rican patient's respect for authority which is generally greater than that of the average American.

The Spanish word *respecto* cannot readily be translated into English, but once the English speaking therapist has experienced the meaning of it he will realize that respect and courtesy must be inherent in his work with this group of patients. This is not only in the matter of being on time or using proper forms of address but, most important, in letting one's own humanness meet the humanness of the other.

It is our belief that students of all disciplines receiving training in such centers as Bronx-Lebanon should have seminars on the Puerto Rican culture and community as part of their regular curriculum. This should surely be included in the training of psychiatric residents. The importance of specific interviewing techniques should be demonstrated for them.

Ongoing educational seminars should also be offered to regular staff, for it is our experience that we all tend to forget factors which are inherently alien to us and revert to manners and methods perhaps personally more familiar. Case presentations and patient care itself should, of course, make the unfamiliar more personally ours.

In conclusion, we believe that psychiatric services to Puerto Rican people must allow for adaptation to language and cultural factors, which in turn will affect the interpretation of various clinical phenomena. This holds special significance for the training of mental health workers who will be treating Puerto Rican patients and for the continued awareness required by those currently doing so.

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SOME DIAGNOSTIC AND PROGNOSTIC SURPRISES IN SPANISH AMERICAN PATIENTS IN COLORADO

Edward G. Long **Richard Hoerl**

Thomas Radinsky

The Northwest Denver Community Mental Health Center is a very large and heavily utilized organization which has responsibility for the core city of Denver, Colorado. Its catchment area manifests most of the problems currently being experienced in many large cities throughout the United States.

Nationally, the catchment area ranks below the 10th percentile in economic and social status and between the 10th and 30th percentiles in educational attainment. It is officially designated as a poverty area and exhibits a high degree of family disruption, overcrowding and residential instability. It houses one of the nation's notorious "hospital without walls," in that literally thousands of ex-State Hospital patients were placed in dilapidated boarding homes and personal care homes when the hospitals began to discharge their chronic patients in the 1960's. The catchment area is of particular interest in the context of this symposium because it also includes a very large number of Spanish speaking, Spanish surnamed persons. To be exact, 30 percent of our 200,000 residents classify themselves as of Spanish origin.

Fortunately, our Center also has a highly developed Research and Evaluation component which not only has compiled several years' worth of voluminous statistical data, but in addition has been something of a pioneer in the field of outcome evaluation. Therefore, we now find ourselves at a point where we can begin to look at differential data relative to utilization, diagnosis, treatment careers and outcomes of large numbers of people of different ethnic groups. This paper will present a few of our preliminary observations and some conjectures as to what they might teach us about the mental health needs of the urban Spanish American.

First of all, despite periodic complaints from Chicano spokesmen that the Center has an Anglo image and will not be utilized by Chicanos, the actual percentage of Spanish surnamed persons in our annual caseload of 12,000 patients is extremely close to their representation in the catchment area: 28 percent as compared to 30 percent in the population. This actually represents a relative overrepresentation of

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adult Chicanos compared to the other ethnic groups because the Spanish surnamed population of Denver includes a much higher percentage of children than either the Anglos or the Blacks. Children of all ethnic groups are grossly underrepresented at our Center, which is true of most mental health centers throughout the United States.

When we look at the intensity of treatment services received, however, we see quite a different picture. Whereas 30 percent of our outpatients are Spanish surnamed, only 20 percent of our inpatients are of that group. Whites tend to be overrepresented on the inpatient service, and Blacks occur in proportion to their presence in the general population, about 10 percent.

In the outpatient service, Spanish Americans tend to have shorter treatment careers, it being twice as likely for an Anglo or Black to stay in treatment 15 or more visits as it is for the Spanish American.

Helping to account for underutilization of hospital services as well as briefer outpatient careers is a strikingly lower incidence of psychosis in the Spanish American caseloads compared to either Anglos or Blacks. Among outpatients, schizophrenia accounts for 13.1 percent of all diagnoses among Whites, 13.4 percent among Blacks, and only 5.2 percent among Spanish Americans. Alcoholism is by far the most common primary diagnosis for our Spanish American patients, but even when both alcoholism and drug addiction diagnoses are subtracted from our caseload, leaving only the more traditional psychiatric diagnoses, schizophrenia occurs in the Spanish American caseload only half as often as it does among the other two ethnic groups. Other psychoses, which in our system would mean manic depressive disease and depressive or involutional psychosis, are even less prevalent, occuring about one-third as frequently as they do among Whites or Blacks. We have only recently become aware of these facts, and we cannot account for them. Perhaps members of this symposium can offer us some insight into these phenomena.

We are currently hypothesizing that another factor which helps to account for less prolonged treatment careers among Spanish American patients is the much greater stability of their family structure compared to either Whites or Blacks of our particular community. Patients without family roots and those who have recently been ejected from a family may tend to develop more dependency on mental health clinicians and may also present with adjustment problems which are more difficult to resolve than is the case with patients who have a familiar base of operations. Whether the larger and more coherent families in the

Spanish speaking community also have something to do with the lower incidence of psychosis in our caseload is not clear.

We have also begun to notice some interesting differences in the outcome of treatment of Spanish Americans compared to the other two major ethnic groups. Our outcome questionnaire, administered by specially trained interviewers 90 days after patients enter treatment, measures several different categories of functioning in addition to client satisfaction. These include psychological distress (which embraces both emotional excess and psychosomatic symptoms), isolation from family, isolation from friends, uncontrolled aggression, non-productivity, legal difficulties, public system dependency, alcohol abuse and drug abuse. Scores for each category have been standardized against a community norm and are compared to scores of intake samples which are taken at regular intervals.

Some of the differences we have noted are these: Spanish speaking males have better follow-up scores than their female counterparts. This is not true of the other ethnic groups. Spanish American females show more psychological distress, isolation from friends and non-productivity at follow-up than any other class of patient. Poor outcome among Spanish American females is particularly striking in those with a primary diagnosis of alcoholism.

Also, as might have been deduced from the strong sense of family among Spanish Americans, those who are either unmarried or separated have worse outcome scores than single patients of the other ethnic groups.

With respect to two other variables, Spanish Americans are no different from other Americans: married adults show better adjustment at follow-up than single adults; and overall outcome in all kinds of patients varies directly with overall income. That is, all other things being equal, poverty correlates negatively with mental health.

There are many other questions we are now in a position to ask of our computerized data banks. Part of our motive in presenting this paper here in Puerto Rico is the hope that this particular audience can help us conceptualize what those questions might be. At the moment, however, we already have four answers which only raise more questions. Working with a patient population of 12,000 per year, 30 percent of whom are Spanish American, 60 percent White, and 10 percent Black, we have found the following: (1) alcoholism or alcohol abuse is the most common presenting problem among the Spanish American caseload; (2) even after correcting for alcoholism, the diagnosis of schizophrenia occurs only half as frequently in the Spanish American group as it does in the White or Black caseload, and other psychoses are even less common; (3) averaging all diagnoses, Spanish American female patients manifest the least desirable treatment outcome of all groups categorized by sex and ethnic origin; and (4) a diagnosis of alcoholism in a Spanish American female seems to have a particularly poor prognosis.

THE IMPORTANCE OF A COMMUNITY MENTAL HEALTH CENTER IN A SPANISH SPEAKING COMMUNITY

Luis H. Velosa

Community mental health centers have been in existence since the early sixties. However, only as recently as December of 1974 did the National Institute of Mental Health, in conjunction with the State of Michigan Department of Mental Health and the Detroit-Wayne County Community Mental Health Services Board, provide the necessary funds to open a community mental health center in Southwest Detroit.

In this paper I will describe briefly the community mental health center and its components and the general characteristics of the Spanish speaking community where this Center operates. In addition, I will illustrate the significant clinical events of a young Puerto Rican who lived approximately 10 years in the state institution, and his transition from the state facility to the community mental health center.

The Community Mental Health Center and the Community

The Southwest Detroit Community Mental Health Center provides six basic services to the community: (1) four satellite clinics for outpatient treatment dispersed throughout the geographical area; (2) a day treatment service or day hospital, which provides viable alternatives to total hospitalization; (3) a 24-hour emergency service, which is located at the local General Hospital; (4) an inpatient service; (5) a consultation and education service that highlights the ethnic needs of the community and aftercare services to the community; (6) and foster home placements and home visiting. The Southwest Detroit Community Mental Health Center has been operating effectively since January 1975.

Southwest Detroit is the oldest section of the city; it is where Detroit originally began. Historically, this area of Detroit was the immigrant "receiving station" for all groups coming into the city of Detroit. A significant number of Maltese, Lithuanians, Hungarians, Italians, and Polish came to this country and settled in Southwest Detroit as first generation immigrants. With rapid industrialization and "progress" these groups moved to the suburbs and now the Black and Spanish speaking population are predominant in this area.

Southwest Detroit is a depressed, declining area suffering from the usual ills of substandard, overcrowded housing, high underemployment as well as unemployment and low average income. These factors create and foster a situation in which severe emotional illness has traditionally flourished. The resultant sense of isolation from society and feelings of impotence from not being able to change one's lifestyle provide fertile ground for social disorganization, drug abuse, crime, suicide and extreme emotional or mental illness.

Other contributing factors add to the sense of deterioration and decay in the community. Schooling is inadequate and teaching methods are ineffectual; dropouts increase daily; home conditions are typified by cramped living quarters; inadequate lighting and poor nutrition—all of which create insurmountable barriers to a motivating and stimulating learning atmosphere. The all too scarce playgrounds and outdoor recreational areas are poorly maintained. Creative and supervised recreational programs suffer continual budget cuts. The lack of such programs increases the monotony, dissatisfaction and unrest among southwest area youth. Older, unskilled workers find themselves phased out of jobs, with little hope of new employment because of their age. Boredom and futility become their daily burden.

In spite of the severity of social, economic, physical and mental health problems, the psychiatric services, before the creation of the community mental health center, were notably deficient as well as poorly adapted to the population.

The Detroit Spanish Speaking Community

The Detroit Spanish speaking community is primarily centered in the southwest section of the city. It is comprised of Mexican Americans, Puerto Ricans, Mexican nationals, Cubans, Spaniards, Colombians, Bolivians, Central Americans and others. Culturally the members of this community, especially those of the older generation, speak Spanish as their primary language and meet day to day needs in their self-sufficient barrio of stores, bakeries, dance halls, bars and barbershops. There are several Latino political, religious and social organizations providing fraternal exchanges. Families are large (with a mean of three children), often extended and generally cohesive.

During the Second World War, Puerto Ricans were brought to Michigan for crop-picking in the northern part of the state. They were unable to provide transportation back to their native country, and the Catholic church brought them to Detroit, settling them in the southwest area.

The predominant Mexican American population includes those who were born in Detroit or have lived in the community several years, recent immigrants from Mexico, seasonal farm workers from Texas, Ohio and Illinois and other U.S. born Mexican Americans who moved to Detroit to work in the automobile factories. Many who are U.S. citizens or permanent residents speak of Mexico as their home. They frequently travel there to visit family and friends and return to Detroit to earn more money.

Many of the southwest barrio residents come to Detroit from rural or small town backgrounds with little education and few skills. They possess a willingness to work long hours at jobs of hard manual labor. Surprisingly, such jobs are often not available.

Most families are very religious, maintain ties with the Catholic church, Pentecostal, or other Protestant churches. At the same time, folk medicine and the use of herbs and teas for treating both physical and emotional problems are an integral part of the Latino culture and are retained to a considerable degree within the barrio.

It is obvious that the socioeconomic status of barrio residents as well as the additional variables of cultural and language differences suggest deep problems. Latino residents, unable to express their needs, become fearful, suspicious, and distrustful of the very agencies that are trying to help them.

Description of a Clinical Case

D. M. is a 36-year-old Puerto Rican man, who, at the age of 17, came to the United States following his older brother who had immigrated the previous year. D. M. is the sixth of nine children. As a child he experienced deprivation and rejection. At the age of 7 his father died; his mother subsequently married a man who had a large number of children. It appears that his mother felt that in order to make room for her new husband's children she had to send her own children to live with relatives. D. M. spent his adolescent years with his aunt. He dropped out of school in the 5th grade, and took up a variety of odd jobs, mainly farm work.

D. M. did not have any difficulties in Puerto Rico, as far as maladjustive or psychotic behavior is concerned. He had adjusted marginally to his environment. He held second and third class jobs (he worked on the land). At times, he would get drunk and fight with his sisters' boyfriends because he felt his sisters were being "bothered" by them. Upon studying his life in Puerto Rico, it becomes evident that D. M. did not exhibit any abnormal behavior that might have suggested a schizophrenic process.

D. M. comes from a poor family who lived in a very deprived rural area of the island. His brother decided to come to Detroit to work in the factories. A year later D. M. also came, with a friend who sponsored part of the trip. D. M. knew very little English and did not have any technical skills that might have helped him compete in the Detroit job market. A year later, however, he was able to secure a job as a migrant worker in Romulus, Michigan, one of the rural agricultural communities near Detroit.

During the next five years D.M. maintained some semblance of stability in his life. He was able to save enough money to move into a rooming house. He had some friends and he was even able to establish a good relationship with his girlfriend.

At the age of 22, D. M. was informed that his mother had died, and it was during that period that all his supportive defenses failed. D. M. began drinking excessively; he lost his job; his girlfriend abandoned him; and he broke his relationship with his brother, who was extremely upset at witnessing D. M.'s regression.

Six months later, D. M. was apprehended by the Detroit Police Department on the complaint of his former landlady. He had broken into his former rooming house and was discovered sleeping in his bed after he had been evicted. D. M. was found guilty of the charge of entering a dwelling without the owner's permission. He was to be sentenced to 30 to 90 days at the Detroit House of Correction. The local priest interceded, however, and arranged an alternative to confinement. He offered to attempt to rehabilitate the patient, to place him in a Puerto Rican environment, and to find employment for him. The probation officer took the patient to the priest's church, and, as they passed the church, he noted that D. M. was crying. D. M. was depressed and would not speak either in English or in Spanish.

About nine days after the patient went to the rehabilitative facility, it was reported that they could do nothing with him and that he was "talking screwy." D. M. was then taken to Detroit General Hospital to be processed and committed to the State Hospital.

I would like to pause here and consider with you what I believe is the best learning experience that his case offers us. If there had existed, at the time of the decompensation that D. M. suffered, a good community mental health center like the present Detroit facility, the Crisis & Emergency services as well as the Day Treatment Service would have been able to effectively treat this patient in the community with much better results. D. M. entered the state system at the age of 22 and at the age of 35 was released to be treated at the local community mental health center, in the Day Treatment Program.

During the first three months in the state institution, D. M. refused to talk. He had no desire to relate to anyone. He exhibited a marked psychomotor retardation. He would get up in the morning and sit in the corner of the ward watching other patients and staff. When he was pressed to talk, he would yell "I can talk, but leave me alone." He was diagnosed catatonic schizophrenic and a major tranquilizer was given.

Five months after his admission he stated, "I feel better now and I would like to go home and back to work." This plea, which is clearly registered in the nursing notes, was not heeded.

Gradually, the patient began to socialize with other patients. He would not talk, but would participate in activities. He would listen to records and dance alone, and would respond sporadically in monosyllables: "Yes, no or I don't know." His psychomotor activity increased; he would spend much of the day walking around the ward "making sounds like animals."

Ten months later, the patient became "increasingly agitated." He was constantly talking to and touching patients and staff. He was transferred to another building because it was felt he needed longer hospitalization since his behavior had worsened. A clearer picture of the patient's condition was needed. He was, therefore, interviewed (for the first time) by a Spanish speaking psychiatrist who, incidentally, felt that D. M. was paranoid and dangerous. During the interview, the patient claimed that his ring and his eyes were endowed with strange powers. The patient was diagnosed to be paranoid schizophrenic, and major tranquilizers were increased.

Five years later there were several attempts to discharge D. M. and transfer him to a convalescent home or family care home, but each time he returned to the hospital because he could not cope with the stresses and responsibilities of the outside environment. Eight years later, at the age of 30, the patient was transferred to one of the Family Care Homes. According to the medical notes, in his third week of living in the home the patient fell or was pushed from the third floor balcony of the home. D. M. had multiple fractures in both legs as well as multiple fractures of the spine. He was taken back to the state facility and stayed there for two years primarily for medical reasons.

At the age of 35, D. M. was transferred to the Southwest Detroit Community Mental Health Center. He has been with us approximately six months. He is a patient in the Day Treatment Service, and his primary therapist is bilingual and also a native of Puerto Rico.

D. M. came to us extremely guarded, suspicious and distrustful. Very slowly he has been developing a better relationship with his therapist. He has been able to share with his therapist his loneliness, the hardships of his life and the various traumatic experiences which he has suffered.

He participates willingly in different activities of the service. We have noticed that his involvement with the staff and other patients has improved and his suspiciousness, his ideas of reference and grandiose ideations are progressively vanishing. Recently, he expressed the wish of learning to read and write better English and also to be able to work someday and be self-sufficient.

Rehabilitation will take a long time. It will be difficult to erase 13 years of institutionalization.

Discussion

The case of D. M. provides still more evidence to support the conclusions of clinic investigators with regard to the impact of mental illness on lower socioeconomic or minority groups. Many investigators have found that individuals from lower socioeconomic groups respond to stress with greater mental impairment (psychosis) than do those from other, more privileged groups. When an individual from a lower socioeconomic group is diagnosed psychotic, he often remains in the hospital for a longer period of time and receives almost exclusively somatic treatment. A member of a more privileged group, on the other hand, is more likely to be treated as an outpatient and to receive psychotherapy.

The striking feature in the particular treatment of D. M. is the gross neglect of his psychological needs. It is difficult to realize that during those long years his cultural values were not recognized, and that there was no one with whom he could communicate meaningfully on a permanent basis in his native language. Hence, this case can be viewed as an example of the necessity of stressing cultural background as a factor in the successful treatment of the mentally ill.

Finally, an issue that remains unresolved is the effect of the community mental health model on the relative success of the treatment of the mentally ill. Up to what point is D. M. going to improve? We do not know. What we do know is that he seems to be happy, he has an interest in his future, and he is establishing meaningful and trustful relationships with people in the community. I think he is beginning to realize now that there is hope of crystallizing those dreams born on the island while he was preparing to leave for the United States.

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WHY WE DID *NOT* ESTABLISH A SEPARATE COMPLETE PROGRAM FOR SPANISH SPEAKING PATIENTS

Ana Anders **Rafael Parlade**

John Chatel **Roger Peele**

For several years there have been various pressures on Saint Elizabeths Hospital to establish separate services for Spanish speaking patients. This pressure is probably felt by many mental health services and it may be useful to explain why we did not do so, even though the Hospital's Acting Superintendent was initially strongly in favor of establishing such a program.

Establishing a special separate Spanish speaking service had an appeal to the Hospital. It was felt that to appropriately treat Latino patients, the staff involved in their treatment should: (1) have an in-depth knowledge of the language, culture and acculturation problems; (2) provide treatment of the problem in a family framework; and (3) assist in the development of community support systems around the client in treatment. The reasons for this appeal centered around a sense that the skills necessary to provide all services should be utilized in a manner that is culturally sensitive and specifically responsive to Latinos.

Recent research findings have demonstrated a high degree of psychosocial dysfunction among Latinos. Frequently, this dysfunctionality appears to result from, or be related to, stresses and demands of acculturation and immigration. Generally, these stresses and conflicts are found at every level of the social ecology, between Latino systems and non-Latino systems which are culturally insensitive to Latino values and idiosyncracies. Most often these acculturational stresses become manifest in conflicts within the extended and nuclear Latino families, leading to the disruption of these families and, thus, to the destruction of the most basic social unit and source of community support to the Latino individual of any age.

Historically, Latinos have relied on their extended and nuclear families rather than on other social institutions for the fulfillment of most needs. When these families become disrupted, not only does the pillar of the Latinos' social support network crumble, but also family members usually fail to seek assistance from social service agencies.

The services presently offered by a special separate Spanish speaking service should have, according to Szapoeznik and Scopetta (1975): (1) psychosocial diagnostics and evaluations; (2) crisis intervention;

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(3) resource referral; (4) individual therapy; (5) family and marital therapy; (6) group therapy; (7) community intervention services; and (8) peer counseling.

There have been many studies done on the general issues of acculturation. The relation of the bilingual individual to his social environment has often been interpreted in terms of the group identification problems of an individual who potentially belongs to two language communities, and, hence, to two societies.

Lambert et al. (1963), who conducted a research study with American students residing in Montreal in which they were required to speak French only for six weeks, found that subjects' scores in both authoritarianism and anomie were higher at the end of the course than at the beginning. These results were interpreted by the authors as indicating that the introduction of a new system of thinking, represented by a new language, produced feelings of alienation, dissatisfaction and emotional confusion. It appears that the subjects attempted to reduce anxiety by adopting a more authoritarian orientation, but this was not too effective, as is reflected in the evidence of increased anomie.

Bilingualism becomes an even more dramatic factor in terms of the purely therapeutic relationship. Speakers of different languages tend to talk about different topics and seem to have different attitudinal and emotional responses that may be found in the experiences associated with each language.

It is in the language that is learned as a child with which the first experiences are labeled. These first experiences have traditionally been considered of paramount importance in shaping the personality and behavior of individuals. Expressions in the mother language are the first ones to be rewarded or punished, and it is in this language that feedback is offered. This is consistent with the hypothesis that bilinguals have stronger emotions attached to the mother tongue than to the second language.

In another unidentified study it was reported that psychotic symptoms in bilingual patients are more easily detected when psychiatric interviews are conducted in the patient's mother tongue than in the second language. This seems to indicate that the patient's more "primitive" emotional world is more readily expressed in the mother tongue.

The research literature on the sociocultural determinants of the behavior of bilinguals indicates that bilinguals' behavior is influenced by their group identification and the social values associated with the two languages. It should be evident that a clear understanding of the bilingual individual's perceptions, values, linguistic and cultural backgrounds is essential to comprehend his behavior as a social being and as an individual.

The handling of persons from a cultural minority requires specially trained bilingual and bicultural staff to deal with clients who are linguistically and/or culturally different and who are experiencing problems of acculturation, such as many of our Latino minorities. Cultural relativity and sensitivity to ethnic diversity is a requisite to bridge the communication gap which, otherwise, becomes an obstacle to effective detention, client involvement and treatment. Being in essence an immigrant minority, many Spanish speaking have sought to retain as much of the familiar as possible. Since Anglo programs have been built around cultural traits that differ to a large degree from those of Spanish speaking people, these programs are in effect unavailable to them.

The hospital established a task force to appraise the hospital's need and ability to carry out a special service. The task force surveyed the hospital and found there were insufficient numbers of nursing personnel in the entire hospital to provide the staff needed for one ward. Instead of a totally separate service, the task force recommended that: (1) Spanish speaking patients be admitted to their appropriate divisions according to their catchment area; (2) a coordinator be appointed to deal with the Spanish speaking patient's needs from the time of admission to the time of discharge; (3) appointment of the coordinator be for a limited period of time (three to six months) in order to evaluate the effectiveness of services; after three to six months, a final decision on disposition would be made; (4) the coordinator be not only bilingual, but also bicultural, with training in clinical skills as well as a knowledge of community resources; and (5) the bilingual and bicultural Saint Elizabeths Hospital staff, who gave us such complete cooperation and offers of future assistance, have an opportunity to volunteer their services to the coordinator.

However, the hospital leader still felt that a separate Spanish speaking unit should be set in motion and be the ultimate goal of the hospital in better serving the Spanish speaking mentally ill. Thus, the issue was taken to the division directors, the Hospital's major decision-making body for discussion. At that meeting the division directors, especially the Spanish speaking directors, spoke out strongly against segregation of services. Reasons given were twofold: (1) to place all Spanish speaking patients together on one ward would be discriminatory (there are many other important patient characteristics and many factors that play a role in mental illness, one should not single out the language spoken as *the* important feature); and (2) Spanish speaking patients are Americans, and are not interested in being segregated. Adjusting to being in a society that primarily speaks English and has cultural differences are obstacles to overcome, not to dodge by isolation. In view of these strongly negative reactions of the Spanish speaking clinicians, the leader backed down and appointed a coordinator as the task force had recommended.

There are two aspects of this decision that deserve amplification. In the first place, one needs to keep in mind that the Spanish speaking professional is one who has often adjusted extremely well to the U.S. society. At Saint Elizabeths Hospital, the Spanish speaking employees probably have a higher average salary than any group including "WASPS." Thus, they have an optimistic sense of being able to overcome language and cultural barriers. An even more important aspect is that any separation within mental health services should fully consider the community's degree of interest in separate services. If there is a large, apparently satisfied enclave in a community that desires separate facilities, then the mental health system might seriously consider the practicalities of establishing a separate unit. When integration appears to be the goal of that Spanish speaking community, separatism should be avoided. If in doubt, it would appear wise to err on the side of integration.*

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*Editors' note: Spanish speaking division directors opposed a separate unit because "Spanish speaking patients are Americans, and not interested in being segregated." Lest they be accused of projection, it would seem appropriate to systematically survey these patients to determine their actual preferences. If sufficient numbers were interested in a facility staffed by bilingual-bicultural professionals, such a unit would be justified. It appears that this decision was made without input from the persons most centrally involved, the patient-consumers.

THE USE OF COMMUNITY WORKERS IN A SPANISH SPEAKING COMMUNITY

William P. Cagel

In recent years there has been increased interest in the use of bilingual community workers in mental health clinics serving Spanish speaking populations. This brief paper is a description of the experience at the Olive View Community Mental Health Center, where a program has been developed utilizing community workers.

The Olive View Center is situated in the San Fernando Valley in Los Angeles County. The city of San Fernando is included in the catchment area. San Fernando is one of the oldest towns in California and is the site of one of the best preserved missions founded by the Spaniards in 1797. There has always been a large Spanish speaking population in San Fernando. The town has been remarkably successful in retaining its identity in spite of having almost been enveloped by the urban sprawl which occurred in Los Angeles and the San Fernando Valley after World War II. A relatively peaceful village in the country became part of the megalopolis with rapid changes in life style as orchards were uprooted and factories and housing tracts sprung up in their place.

The utilization of the mental health facilities by Spanish speaking individuals at Sylmar was virtually negligible in the past. A major factor in this underutilization of the facility was the relative inaccessibility of the clinic. Bus service was so infrequent as to be virtually useless. Appearance of a client for treatment who was unable to speak English usually represented a minor calamity for all concerned, because of the limited number of Spanish speaking personnel. It would have been simple to subscribe to the myth that there was no need for services to the Spanish speaking, as they rarely presented themselves.

The mental health clinic was totally destroyed in the early morning hours of February 9, 1971, by an earthquake. A few days later a still somewhat dazed staff was dispersed and assigned to other facilities in the county. The Director of the County Health Department facility in San Fernando provided space for several members of the staff and operations were promptly set up. Most of the clinic staff made arrangements to continue with their former patients in the new quarters.

In the meantime, a team of volunteers, in cooperation with mental health clinic staff members, started a door-to-door survey of the area in which the heaviest damage had been sustained. The survey was set up to determine the need for various services in the disaster area. It also served as a means of acquainting the residents of the area with services which were available, such as Small Business Administration loans to help in financing home repairs. Approximately 250 families were located in which there were emotional reactions which had proved extremely disruptive; innumerable minor adjustment reactions were also uncovered. Referrals were made to the mental health clinic where appropriate. Many of these affected individuals were Spanish speaking, and a number of them went to the newly opened facility. Unfortunately there was no staff, at that time, to treat them.

During this period the decision was made to employ two bilingual community workers. Two suitable candidates were suggested by the parish priest and in due time were added to the staff. The workers were Lupe Barragan and John Hernandez. In looking back, both recall a feeling of apprehension about what they were getting into. Lupe recalls, "I felt I was going into limbo. It seemed strange to be going into mental health. I'm a better listener than talker. I worried about what I'd say." John says, "I was in shock. I wondered what I was doing here since I didn't know anything about it." Despite their fears, what both did possess was an intimate knowledge of the community and its problems, and a sensitivity to the needs and feelings of the patients.

At first, both community workers spent much of their time in the community in an "out-reach" program. Contacts were made with the schools, police department, probation department, churches, community centers and family service organizations.

There were occasional rebuffs. One school principal told John that he would "prefer to deal with someone who is not a layman." Happily, this encounter was followed by success at another school which opened the way to increased acceptance and gave the workers some local fame. John Hernandez arrived at a local school one day to talk to the principal at a time when there was grave concern that a major riot was about to break out between the Anglos and the Mexican Americans. Tension was high. The students had refused to go to their classes and were milling about the school grounds, ready for battle. It was the day before Cinco de Mayo and John proposed that a Mexican flag be raised along with the United States flag. Immediately after this was done there was a noticeable change in the atmosphere at the school and order was readily restored.

Fairly intensive training and supervision was provided by the clinic director and various staff members during the first six months. At the same time, the community workers were able to contribute to the understanding of the cultural background and pressures bearing on the patients who were coming in increasing numbers. Weekly supervisory sessions are still scheduled, but the most productive interchanges occur in brief consultations which occur at odd moments and during coffee breaks. During the last year since I became director, I have probably learned more from the community workers than they have from me. At their suggestion, a more informal intake procedure was established. Fortunately, the clinic was situated in a bungalow where no amount of effort could have recreated the atmosphere of the former clinic building.

As time has passed, the clinic's name and presence have been established. Lupe Barragan has confined her activities to the clinic and John Hernandez divides his time between the community and the clinic.

The clinic is now set up to enable drop-ins to be seen immediately. At the initial visit, the urgency of the presenting problems can be assessed and proper recommendations made. There is no waiting list and therapy can be instituted immediately. Frequently it is a matter of making a proper referral. Other times, help is needed to guide the client through the bureaucratic maze, which in Los Angeles, can bewilder the most sophisticated. It requires considerable expertise, persistence and assertiveness to manipulate the system locally, and it is easy to understand why many give up in despair. Lupe Barragan and John Hernandez have mastered the intricacies of the system and function effectively as local ombudsmen.

We provide a modified psychiatric emergency team service as well. If there is a call regarding a disturbed patient who is unwilling to come in, John Hernandez will visit the patient at home. Usually this is done with a priest and occasionally Mrs. Hernandez goes along. The usual result has been that the patient responds by coming into the clinic or going to the Psychiatric Emergency Clinic for treatment or hospitalization.

When it was noted that a number of patients who had been referred for follow-up after hospitalization were not coming in for their medication, arrangements were made by the first director to visit them in their homes. This was so successful that a so-called "Prolixin run" was set up on alternate weeks. A community worker accompanies the clinic director on home visits and medication is taken to the patient or I. M. Prolixin is administered. The majority of patients have welcomed these visits and have been very hospitable. In the course of the home visits, problems have frequently been disclosed to the community worker which might never have been revealed in the clinic. Interactions with other family members who come and go during the visit frequently contribute to the understanding of the patient's problems and conflicts. There is no doubt that the treatment has been more efficacious than if Prolixin had been administered to a protesting patient who had been brought to the clinic unwillingly. With passing time, most of the patients come voluntarily to the clinic after they have become acquainted with the staff.

Mr. Hernandez has developed skill in working with couples or families who are having problems with one or more of their children. Having been born in Mexico and brought up in this country, he is sensitive to the reactions of the children who are rejecting the old values and rebelling against parental authority.

Mrs. Barragan has a large case load of depressed housewives who constitute a large percentage of the clinic population. Fortunately, these are the patients with whom she feels most comfortable and works most successfully.

Both workers report that the most troubling aspect of their work is the recurrent frustration of their desire to be more helpful than they feel they are. The community workers joined the staff in October 1971. Unfortunately, no statistics enumerating the number of Spanish speaking patients receiving treatment at the clinic were kept before February 1972. In February 1972, 25 percent of the patient visits were Spanish speaking. In November 1972, 40 percent of the patient visits and 48 percent of the case load were Spanish speaking. During the last six months of 1975, slightly over 55 percent of the patient visits were Spanish speaking. The population of San Fernando is estimated to be 49 percent Spanish surname, so our clinic is apparently serving a representative sample of the people in the community.

We are very aware that there are many needs which are still not being met. Our goal is to improve the services to the community. The community workers have been of invaluable assistance in helping the clinic reach the present level of acceptance and utilization by the Spanish speaking members of the community, and it is expected that their contribution to further progress will be of vital importance.

In summary, the community worker can be used in the following areas:

1. Community relations—to bring the clinic into the community, making the people aware of its services and usefulness.
2. Community acceptance—to demonstrate to the community that the facility is not to be feared, and that it can be helpful to many people and groups.

3. Liaison with other community agencies—to coordinate the clinic's work with other indigenous agencies in the community as well as bureaucratic agencies that the patients need, but have difficulty in using.
4. Out-Reach—to function as casefinders in the community so that the entry into the system by the patient is facilitated.
5. Intake evaluation—to participate with special qualifications in this process since they might be able to see the usefulness of other community agencies for the patient; to refer and expedite.
6. Continuity of care—to make home visits utilizing relationship therapy in this more relaxed or less formal atmosphere.
7. Home visits with other professionals, such as the psychiatrist—to give medications or suggest other treatments.
8. Group therapy—to enrich the group experience as co-therapist with other professionals by bringing in understanding of the culture where needed, especially in socialization and relationship groups with isolated chronic patients. Supervision is continuous.
9. Individual therapy—to provide sympathetic listening and relationship therapy under close supervision.

SUBTLE BIAS IN THE TREATMENT OF THE SPANISH SPEAKING PATIENT

Frank Kline **Frank X. Acosta**

William Austin **Richard G. Johnson**

Few deny bias exists and prejudgment occurs. Saunders (1954) observed this problem in medical care, and Kline (1969) in psychiatric treatment. Psychiatrists share mankind's common preconceptions about people or groups of people. Yamamoto et al. (1967) have noted and described this phenomenon. Nor is prejudice a one-way street. Acosta (1975) and Kline (1969) note that the Latino patient has his own stereotype of the Anglo.

Thus, it seems abundantly clear that biased prejudgments occur and affect the treatment offered, the patient's initial attitude towards therapy, and the therapist (Acosta, 1975). It has also been demonstrated that a therapist's lack of interest (and therapists are not usually as interested in people from different backgrounds and cultures) affects whether or not the patient returns (Kline et al., 1974). In this study we were interested in seeing if working through a Spanish-English interpreter led to an alleviation or exacerbation of potential misunderstandings between therapists and patients.

Method

Patients were asked to fill out a questionnaire after their initial interview which assessed their level of satisfaction with various aspects of the treatment they had received. A graduate research assistant made certain each patient receceived a questionnaire and that it was returned. Twenty-one patients who spoke only Spanish and 41 Spanish surnamed, English speaking patients returned the questionnaires. The data were tabulated and compared with the responses of 146 consecutive patients obtained in a prior study (Kline et al., 1974). We then surveyed the 19 psychiatric residents who did the initial evaluations and compared their responses to the patients' responses.

Results

Both Spanish surnamed groups of patients, those who were interviewed through an interpreter, and those who were interviewed directly in English, appeared in general to be as satisfied with the services provided by the clinic as were a previously sampled group of 146

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patients. But, Spanish surnamed, English speaking patients were noticeably less pleased with the doctor's specific advice, and with the help in developing self-understanding.

Patients interviewed via interpreters found understanding and specific direction more helpful than did English speaking Latinos and as helpful as our "average" patients. They thought they were helped and understood almost twice as often as English speaking Latinos. Patients interviewed through interpreters got medication more often and found it about as helpful as patients interviewed directly in English, but both Latino groups were less satisfied with medication than our "average" patients.

Our resident physicians consistently misinterpreted their value to Spanish speaking patients interviewed through interpreters. The residents did not think patients understood them, nor that they understood the patient. They did not think that patients were eager to return for subsequent visits. Our second year psychiatric residents were not comfortable seeing patients who required an interpreter beyond the initial interview.

Conclusions

It seems clear from this study that our resident physicians think their frustration, uncertainty, and feeling of inadequacy in an initial evaluation conducted through an interpreter is shared by the patient. The physician's doubt about his effectiveness in another language and across cultural barriers is unfortunately reinforced by some well meaning mental health professionals. This outside reinforcement by experts increases the Anglo therapist's discomfort and doubt when working with any Latino patient, and especially with the patient who speaks no English. The physician, perhaps partly because he feels helpless, is reluctant to see the patient again, and writes what seems to be an excessive number of prescriptions.

While most of our patients find prescriptions generally helpful and useful, patients interviewed through an interpreter find medication less helpful. This suggests that prescription writing might be done partly because the physician wants to do something and does not feel the interview provides adequate help.

There is no question that working through an interpreter is difficult, confusing, time-consuming, and plain hard work. Hard work alone will not generally discourage a physician. What does discourage a physician is the feeling that he is not helpful or effective. Discouraged therapists lose interest in their work or become annoyed with the patient. Disinterested, annoyed therapists drive patients away (Kline et al., 1974). Even if the patient wishes to continue and asks to come back, the therapist who feels ineffectual tends to terminate the patient, refer him elsewhere, or to write prescriptions. Our patients interviewed through interpreters do not seem satisfied with prescriptions and there is nowhere else to refer them except to already overburdened Spanish speaking mental health professionals. Neither course is appropriate. Our data suggests that a return visit is the most appropriate course to follow.

Our data does *not* suggest that minority mental health professionals are not necessary or appropriate. In terms of simple economics it takes twice as long to work with a patient through an interpreter. This is not the most effective way of using interpreters or psychotherapists. There is also no question that the minority mental health professional brings special understanding and even special skill to the psychotherapy of all patients, not just patients from his particular background. Thus, we must actively recruit, encourage and employ mental health professionals from all cultural backgrounds. But until there are enough bilingual Latino therapists to treat most Latino patients, it is a disservice to the patient to reinforce the idea that Latinos neither like nor trust Anglos and that an Anglo therapist is grossly ineffective in treating Spanish surnamed patients. In our efforts to convince ourself and others of the necessity for more minority therapists, we should be careful not to undermine the confidence of existing therapists and thus leave some of our patients mistreated or undertreated.

TABLE 1
Percentage of Positive Response Only*

	(N = 146) Column 1	(N = 41) Column 2	(N = 21) Column 3
	All patients after 1st visit	Spanish surnamed after 1st visit	Spanish speaking after 1st visit
A. Were the following helpful?			
1. Arranging appointment	85%	92.7%	95.2%
2. Registration	90%	73.1%	85.7%
3. Therapist interest	86%	85.4%	85.7%
4. Therapist appearance	89%	87.8%	95.2%
5. Therapist service generally	87%	82.9%	90.5%
6. Medication	83%	39.0%	57,2%
7. Understanding (self)	87%	53.7%	80.9%
8. Specific directions (specific advice on my problem)	76%	58.4%	85.7%
B. Did the doctor help you with your problem?		41.5%	76.2%
C. Even though your doctor couldn't speak Spanish, was the interview helpful?		41.5%	76.2%
D. Would you like to have continued to see the doctor for more visits?		73.2%	71.4%
E. Do you feel the doctor understood you?		65.9%	76.2%
F. Did you think you understood the doctor?		73.1%	76.1%
G. What did the doctor do?			
1. Advised me what to do		56.1%	61.9%
2. Gave me medicine		41.5%	71.4%
3. Suggested I go to another clinic		7.3%	4.8%
4. Didn't know what to do		4.9%	9.5%
5. Mainly listened to me		51.2%	90.5%
6. Other		7.3%	4.8% (group)

*Column 1 lists percentage of "good" responses from the possible choices of "good," "fair" and "poor." Columns 2 and 3, question A, list responses of "excellent" and "good" where possible choices were "excellent," "good," "fair" and "poor." In questions B-F, the choices were "very much," "in general," "very little" and "not at all." Responses were considered positive only if "very much" was checked. In question G, percentages indicate items that were checked by the patients.

TABLE 2
Resident Physician Responses

Question	+	%	-	%
1. An initial interview is satisfactory to me when the patient speaks English.	19	100	0	0
2. The patient appreciates the session more when we both speak English.	15	79	4	21
3. I think that patients see themselves as helped more when we both speak the same language.	19	100	0	0
4. I think that patients are eager to return for subsequent visits when interviewed via a translator.	5	27	14	73
5. I think that patients interviewed via a translator feel they communicate better than do English speaking patients.	3	16	16	84
6. I think that patients feel they were better understood when they can talk to the therapist without a translator.	16	84	3	16
7. I feel comfortable seeing a patient in psychiatric treatment with the help of a translator beyond the initial interview.	2	11	17	89
8. I think I help non-English speaking patients just as well with a translator as I do English speaking patients with no translator. (One blank.)	0	0	18	100

+: Agree strongly, Agree, Agree slightly
-: Disagree slightly, Disagree, Disagree strongly

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DO LATINOS AND BLACKS PARTICIPATE IN OUTPATIENT SERVICES CONSUMER SURVEYS?

R. W. Burgoyne

George Wolkon **Fred Staples**

The Adult Psychiatric Outpatient Clinic of the Los Angeles County-USC Medical Center is nestled in one of the largest metropolitan areas of Spanish speaking people in the world: East Los Angeles. Ten years ago a study at our clinic revealed that, in ongoing psychotherapy treatments, socioeconomically deprived minority patients were poorly represented in comparison to both the population of the catchment area and those presenting themselves for treatment (Yamamoto and Goin, 1966). Concentrated efforts on the part of the clinic director and staff to increase minority utilization of services succeeded to the extent that by 1973 minority patients were offered and received psychotherapy in proportion to their distribution in the population.

In March 1975, the Department of Evaluation and Research of the Los Angeles County Mental Health Department conducted a "Client Satisfaction Survey" at all county funded treatment facilities. The questionnaire covered the patient's satisfaction with services received and his or her perceived improvement in various aspects of life as a result of therapy. Over 2,000 questionnaires, 42 percent of those distributed, were returned countywide. They indicated 91 percent of patients were satisfied with the services overall and 84 percent perceived their therapist as helpful (Goidberg, 1975).

A great deal of effort had been expended to obtain a valid sample of the patient population. A sufficient number of questionnaires were given each facility to provide an adequate sample of patients receiving care. A consecutive patient sampling method allowed for the inclusion of patients participating in all types of treatment modalities. The patients anonymously and voluntarily completed and returned the questionnaires. The only identifying mark on the form indicated the treating agency.

Systematic factors thought to influence the return rate of the "optional and voluntary" questionnaire, which bias the results, were: length of the form, reading skill required (74 questions and ninth-grade reading level), language of the questionnaire, and therefore, the primary and perhaps exclusive language of the patient, type of therapy

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the patient was receiving, the extent of the patient's psychopathology, various demographic differences, and length of clinic contact.

To determine the type of patients who did voluntarily return the form, this study examined the portion of the countywide survey that was done at our clinic, and compared available characteristics of the patients who returned the questionnaire to a collection box with those who did not.

Method

As they arrived at the clinic on March 3, 1975, 128 consecutive patients were handed an "optional and voluntary" client satisfaction survey questionnaire. Twenty of the 128 patients were Spanish speaking and were given a Spanish version of the questionnaire.

The answers to the survey questions themselves remained strictly anonymous. However, all 128 patients were unobstrusively observed by the registration clerks as either returning the questionnaire in sealed envelopes to an appropriately marked collection box in the waiting area, or as failing to do so. Information on a number of possible variables was gathered from records, after which the data were analyzed for significant relationships between characteristics of patients who were seen to return the questionnaire in the collection box and those who were not.

Results

The entire sample (N = 128) included 42 men and 66 women. Forty-eight percent (N = 61) of all questionnaires were seen to be returned to the box, a rate of 6 percent greater than the countywide return rate.

Comparisons between those who did and did not return the questionnaires to the collection box were made on the following variables: ethnicity, education, type of medication, sex, age, income, marital status, prior psychiatric hospitalization, religion, English or Spanish speaking, type of treatment, frequency of treatment, length of treatment, attendance, and psychiatric diagnosis. Chi square tests of statistical significance were performed utilizing all available categories for each variable and collapsed groupings of the multicelled categories. Further, the comparisons were made for the entire sample, separately for the English and Spanish surnamed subgroup, for English and Spanish language subgroup, for each sex, and for each treatment modality.

Three significant differences emerged consistently in the total sample and the subgroup analyses. A higher return rate was associated with minority group membership (Blacks and Spanish surnamed caucasians), lack of high school education and treatment with antipsychotic medication. If an individual was a member of a minority group (a "non-Anglo") and had less than a high school education, and was taking antipsychotic medication, his chances of returning the questionnaire to the collection box was 79 percent as compared to the 30 percent chance of the returning if he had none of those three characteristics. When ethnicity is broken down into Spanish surnamed, Black, and "Anglo," this result persists as a strong trend, but fails to attain statistical significance.

TABLE 1

Ethnicity, Education, Medication and Questionnaire Return Rate to a Collection Box

Subject Variable	Returned	Not Returned	X2	p
ETHNICITY				
Anglo (N = 62)	37%	63%	5.37	<.05
Minority (N = 66)	58%	42%		
EDUCATION				
Below high school (N = 59)	59%	41%	5.97	<.02
High school & above (N = 69)	38%	62%		
MEDICATION				
Antipsychotic (N = 56)	62%	38%		
Other drugs (N = 31)	39%	61%	8.50	<.02
None (N = 40)	35%	65%		

TABLE 2

Ethnicity and Questionnaire Return Rate to a Collection Box

Ethnicity of Subject	Returned	Not Returned	X	p
Spanish surnamed (N = 43)	58%	42%		
Black (N = 21)	57%	43%	5.427	ns
"Anglo" (N = 62)	37%	63%		

Only eight of the Spanish language questionnaires were seen to be returned to the box, while twelve were not. Because of the numbers involved, this difference is not significant; Spanish and English questionnaires were statistically returned in equal proportions.

Discussion

The finding that ethnic minority patients with less education more frequently returned a long and difficult questionnaire refutes a common view that assumes that client satisfaction questionnaire research excludes the views of ethnic minority patients. If anything, they, along with the less educated and the chronically ill, respond more consistently.

Antipsychotic medication significantly differentiated patients who returned the form, but assigned diagnosis did not. This may be because the assigned diagnosis listed in the chart for anyone to see does not always correlate with the actual opinion of the physician. As insurance companies have discovered, the physician's true opinion about the presence of psychosis is more likely revealed by his use of antipsychotic medication.

Ethnic minority patients with a chronic mental illness and who are less educated are likely to perceive a greater need for the clinic. In actual fact, they may have fewer options. If so, they are under more pressure to conform and "voluntarily" return a questionnaire assessing their satisfaction with treatment. This control, whether actual or merely perceived, greatly influences voluntary response to requests (Wolkon, 1971).

In essence, volunteering may be viewed as a special type of conformance. Although it is an individual act, it is in fact influenced by a multitude of internal and external stimuli, many of which are essentially unidentifiable. This study suggests that dependence produced by relative sociocultural inadequacy is one of those stimuli that place patients in at least a perceived state of diminished freedom. This diminished freedom might account for this group's increased immediate conformity implied in their increased return rate of questionnaires.

As an option, patients could elect to mail the questionnaire directly to the Department of Mental Health. An additional 20 patients did so. Although these questionnaires could not be separated from those returned in the collection box, self-identification of ethnicity allowed us to determine that a slightly, but significantly, greater proportion of "Anglos," compared to Spanish surnamed and Blacks, used the U.S. Mail to return the questionnaire. It is, therefore, important to use both methods of return to better approach an unbiased sample, and very important to provide for return via a collection box at the agency in order to include the representativeness of the Spanish speaking and Blacks.

It should be noted that most of the many variables examined in this study do not significantly influence the return rate of a voluntary questionnaire. This fact should be reassuring to those who feel services and surveys often exclude the population for which they are aimed, and instead characteristically fall to the "silent majority." This study demonstrates that the ethnic minorities, the less educated, and those on antipsychotic medication responded more often to a consumer survey and reported that they are satisfied with the services.

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DAY TREATMENT OF HISPANIC ADOLESCENTS INVOLVED WITH THE COURTS

Alvin H. Richmond **Raymond Manning**

James Maldonado **Mishelle Ross**

There is a growing concern about the alarming increase in the severity and number of crimes committed by young adolescents (under 16). Acts of homicide, rape, assault and robbery are not uncommon. Society is faced with the problem of how to legally deal with these massively damaged, asocial adolescents and also how to intervene in some rehabilitative sense to enable them to join society in a meaningful way.

It is recognized that for most of these adolescents, the antisocial acts are the tip of the iceberg of a whole range of problems—poverty, broken families, inadequate housing and health facilities, subculturally approved violence and inappropriate educational programs. By the time they become involved with the courts, these adolescents have had a long history of truancy, minor crimes, violent acts and mistreatment. In addition to the severity of these problems, facilities to deal with these adolescents are appallingly inadequate. Massive shortages of staff and services lead to overcrowding, inadequate and abbreviated handling of these traumatized and trauma-inducing young people. The difficulties are further compounded by exposing the adolescent who has committed a serious crime to a whole string of destructive interactions via the services set up by the judicial system.

In the South Bronx, where a majority of the population are of Hispanic descent, there are massive problems in dealing with delinquent adolescents. It has been well documented that this is an urban disaster area. The indices of social pathology are very high: 40 to 50 percent of the population are unemployed and on welfare; infant mortality and homicide rates are high. Not unexpectedly, problems of youth in legal difficulty are of epidemic proportions. The delinquency rate is 10 percent and 96 percent of the Juvenile Court intakes for probation for the entire Bronx come from this area.

To begin a systematic attempt to cope with this problem, the Department of Psychiatry of Lincoln Hospital of the Albert Einstein College of Medicine has instituted a program which we hope will develop into a model program. This new program involves the establishment of an Adolescent Day Treatment Center for youths between the ages of 11

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and 15 years in trouble with the law. It provides a whole series of treatment modalities to deal with these adolescents and their families. It is an intensive and extensive program stressing active intervention and community involvement.

This program is located in the heart of the South Bronx. Of the adolescents served, 75 to 85 percent are of Hispanic background (primarily of Puerto Rican descent). In their families Spanish is the primary language. We were impressed by the fact that on the basis of population, adolescents of Hispanic background were greatly overrepresented. We believe that this has special significance to further understand this first and second generation group. We were thus provided with an exciting opportunity to examine and actively intervene in this area.

Clinically, the Adolescent Day Treatment Center goals are to: (1) provide a total milieu of growth, understanding and commitment, by having its clients participate voluntarily; (2) incorporate within the psychiatric model a treatment program where emotions could be brought out expressively; (3) provide a structured program to fill gaps in the lives of its clients; (4) begin dealing with the low threshhold of frustration many clients exhibit; and (5) eradicate violent behavior, symptoms and patterns.

We use the social work model of groups and group therapy to enable us to accomplish our goals. All clients are put into one of the two groups which provide them with their daily care. In addition, therapeutic community sessions are conducted twice weekly, and the clients are then further split into therapy groups. The immediate benefit is that while all the adolescents had difficulty maintaining peer relationships prior to coming to the Center, given such a wide range of groups, they do succeed in establishing some meaningful relationships.

Contracts are established with all the clients stipulating the conditions of their continuance in the program. These contracts serve the purpose of setting up a clear, definable set of rules which all (adolescents and staff) are to comply with, as well as providing the necessary drive to continue in the program.

A behavior modification program is established, based on a positive point system. Since the client's threshold of frustration tolerance calls for very limited and specific rewards and tasks, points are given for desired accomplishments, while negative, acting out behavior does not result in the withdrawal or elimination of points. Many adolescents are often frustrated with the amount of work that they have to accomplish, and refuse to continue or to finish their assignments. Rather than take away what is already theirs, we provide for a change of milieu or activity until the adolescents are ready to continue. Since many of our adolescents do not have any visible guilt feelings or remorse over their actions, the elimination of points would further frustrate the adolescent once he calms down or is ready to continue his work.

Staffing consists not only of the usual psychiatric team—psychiatrists, psychologists, and social workers, plus paraprofessional mental health workers—but, in addition, there are other major professional inputs. The New York City Board of Education has established a special school within the project including a free breakfast and lunch program. Specially trained educators emphasize individual tutorial classwork. A Vocational Rehabilitation activity program stressing concrete work oriented tasks is a vital part of the program along with its concommitant recreational component. Also included is a community outreach program that involves hospitals, community centers, state recreational facilities and other resources. Active involvement in the adolescent's life in the community is a vital part of the project—home visits, street work, etc. Network family therapy and various group approaches (e.g., mother's group, children's group) are stressed. Liaison and referral contacts have been established with the Family Court, social agencies, children's shelters and other institutions which come in contact with these youths.

Many treatment issues of an explosive nature are constantly in the forefront, requiring frequent examination and re-examination. A very intensive inservice training program is an integral part of the project. Issues of contagion, contamination, asocial activities, rage, helplessness are constant sources of concern. Powerful counter-transference reactions are frequently stirred up and dealt with.

Though we anticipated a whole range of situations, we have encountered many unexpected problems and experienced some surprising positive experiences. We have many concerns about the viability and at times about the usefulness of this program. We are involved in a constant evaluation of its effectiveness. At other times we believe that a program like ours, properly modified for local conditions can be readily applied in many other settings to meet a great and growing inadequately handled societal problem of the interplay between acculturation and psychosocial pathology.

THE LANGUAGE HANDICAPPED PSYCHIATRIST AND PATIENT: THE BILINGUAL SITUATION

A Summary of a Panel Discussion

Walter Tardy

The problem of the language handicapped psychiatrist and patient is ubiquitous. On our panel we had mental health professionals from Canada, Puerto Rico and five states, representing both urban and rural areas. Interestingly, all participants could cite instances where problems in communication were major obstacles to overcome.

The most extreme example of the problem of communication between therapist and patient is when neither speaks the other's language at all. This extreme lack of language similarity between patient and treatment staff is indeed criminal, especially when it occurs in already limited treatment settings, as in state psychiatric hospitals.

How does the psychiatrist handle the patient who does not speak his language at all? The medical model of working with aphasic patients can be used as an example. First, the therapist must understand how the patient feels in his situation. The therapist must have the ability to empathize with the patient, yet maintain his own identity. When working with the aphasic patient we write, use pictures, sign language, and we touch the patient. Through these efforts, real communication occurs. These same principles can be used in working with the patient who does not speak our language. I emphasize touching the patient because of what it means to the patient: you are here, you are a person, I respect you, you are clean, and you are not dirty. These are nonverbal manifestations of empathy and concern.

Fortunately, in most patient-therapist interactions, the language problem is not this extreme. The therapist usually has some familiarity with the patient's language and culture. However, the patient should not be looked at simply from a linguistic or cultural point of view. In the bilingual situation the therapist may project his own feelings of anxiety and inadequacy upon the patient, so that in effect, the dilemma is seen as "the patient's problem."

The psychiatrist has a task, if he is to maintain his professional integrity, to look beyond the surface and explain the inner world and the psychic reality of the patient as he experiences his culture. The psychiatrist should be aware of where culture ends and psychopathology, if present, begins. Due to the close link between language and culture, if

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we remove the native language of the patient we get a different view of his psychic reality as he experiences it. There are many levels on which the psychiatrist can communicate with the patient. On a cognitive level, the verbal content of the language is important. This becomes a problem in translation if the psychiatrist is dependent on a translator and depends on the verbal content alone. At issue is whether despair or suidical tendencies can be translated adequately. Often this is a problem when one speaks the same language as the patient. How many times have we questioned our perceptions and wondered if the patient would *really* commit suicide. This brings in the second level of communication—the nonverbal, which can bring the therapist closer to the psychic reality of the patient. In the once or twice contact of the diagnostic evaluation or the longer contact of psychotherapy, nonverbal communication plays a significant role in establishing rapport. Trust and the therapeutic alliances built on both patient and therapist work jointly on the issue of communication. The therapist is obligated to let the patient be aware of his lack of knowledge of the patient's language. This does not mean that the therapist should shy away from using familiar phrases he does know in the patient's language. However, he should not make himself appear phoney by mimicking the language of his patients.

Should the language and cultural dissimilarity between patient and therapist be viewed only as a handicap? Our panel thought not. The therapist should use this patient encounter to open himself up and expand his level of awareness through his or her interaction with patients from a different culture.

Some practical and immediate solutions to the problems of communication between patient and therapist are as follows: (1) an increase in the number of bilingual employees in hospitals and clinics; (2) more bilingual translators to supplement the translation done by employees on a voluntary basis; (3) more extensive use of volunteers such as college students as language interns who would get college credit for the experience; (4) a network for translation over the telephone, as has been established in several cities with a 24-hour operation; and (5) establishing a referral service and refer patients to psychiatrists who speak their own language, as is done by the New York County District Board of the American Psychiatric Association for its 1500 members in Manhattan.

In the educational sphere, Ms. Mercedes Colon described a training program at New York University where second-year medical students are offered an elective of an interview course in Spanish that is coordinated with the ward in physical diagnosis. This program has been enthusiastically received by the students; 120 out of 170 students enrolled, and it allowed them to work more effectively with the Spanish speaking patients at Bellevue and University Hospitals. Dr. Victor Bernal at the Hato Rey Psychiatric Institute in San Juan, Puerto Rico, has developed a program for training residents in psychiatry to become fluent in Spanish and to work with Spanish speaking patients. His program emphasizes the learning of the culture as well as the language.

The problem of who is to speak what language and where is a complex political issue. An example is the language-political problems of Quebec, Canada, as well as the controversial bilingual programs in the public school systems in the northeast and southwest United States. The role of the psychiatrist, psychologist, social worker and other mental health professionals in this controversy should be to demonstrate the scientific studies at the highest level in the effects of language deprivation on the psychological development of children. Thus, the mental health professionals can ally themselves with the educators and others interested in such solutions to the problems of language and communication in a larger societal context. Therapists should be expected to take a more active role in learning the language of the patients, and accept some of the responsibilities in solving this significant and enormous problem of communication.

PHARMACOTHERAPY HERE AND ABROAD: DIFFERENCES IN SIDE EFFECTS

A Summary of a Panel Discussion

Ronald Fieve

As an introduction to the topic it was decided by the panelists and the participating psychiatrists from here and abroad that the group would first of all systematically examine the actions and side effects of the following major classes of drugs, and then sort out differences between the various countries and cultures: major tranquilizers, minor tranquilizers, tricyclic antidepressants, MAO inhibitors, lithium carbonate and hypnotics. The group decided to concentrate on whether differences exist between cultures in pharmacological, behavioral and psychological actions of these compounds. Approximately half of the session was therefore devoted to a review of psychopharmacology. Both short-term and long-term behavioral, physiological, neurological and psychological side effects were discussed. The group agreed that differences and side effects do exist, but only to a modest degree in different cultures since the physiological effects of most psychotropic drugs are randomly predictable. Relatively constant behavioral changes and side effects are the rule despite the culture in which the drug is administered. However, the psychophysiological response to a given compound may vary from person to person regardless of culture, due to genetic control of the metabolism of many of these substances. Thus, a given behavioral response and side effect may in part depend on the concentration of metabolite in the blood, which is genetically determined. A few pharmacogenetic studies (e.g., MAO inhibitor, tricyclic, and lithium research) have assessed clinical responses to a given class of drug within members of a given family pedigree. Results have thus far suggested that members of the same family suffering from an affect disorder have similar clinical responses or lack of response. There has been no corresponding intercultural research on pharmacogenetic differences and the panel proposes this as an important area for future collaborative research between the U.S. and the Caribbean countries.

With respect to overall behavioral side effects, the panel was unable to discern any major differences. Minor differences were described in photosensitivity, disclosure of impotence, weight gain, intolerance to anticholinergic symptoms in the Caribbean at comparable doses of the

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same compound used in the United States and increased likelihood of mild lithium side effects in tropical as compared to northern climates.

Photosensitivity seems to be an increased hazard for light-skinned northern patients on phenothiazines who vacation or move to the Caribbean. Dark-skinned patients on phenothiazines do not seem to have this same problem whether living in the United States or the Caribbean Islands.

A second cultural difference relates to the wife's willingness to disclose the side effect of impotence in the husband who is treated with certain psychotropic drugs. Caribbean women appear much more reluctant to discuss this side effect than American women, who often exaggerate rather than minimize or hide the dysfunction.

Weight gain was a third side effect whose acceptance seemed to vary with culture. However, tolerance for weight gain seems to be related as much to social class as to culture.

The panel noted that there was less tolerance of the anticholinergic side effects of the neuroleptics and antidepressants in the Caribbean Islands. The typically effective daily dose of tricyclic antidepressants, for example, is 50 to 150 mg. for a Caribbean patient. It is not unusual for patients to require 250 to 300 mg. of the same antidepressant in the United States to achieve the same clinical response. Side effects, such as dryness of the mouth, constipation, hypotensive effects and drowsiness, are more easily tolerated in the United States culture.

One possible explanation for the lower tolerance of anticholinergic effects in the tropics is the more rapid induction of postural hypotension where there is an excessive loss of salt with a resultant negative sodium and/or fluid imbalance. This hypothesis could be tested in the Caribbean outpatient department drug clinics with one group of patients receiving standard antidepressants in the usual dosage and a control group matched for age, sex and diagnosis receiving the drugs in doses comparable to that given in the United States, but with sodium supplements and greater attention to precisely controlled daily intake of fluids. We mention this as a second area of possible research collaboration between the northern and the tropical countries. Finally, with respect to the use of lithium carbonate, information on side effects in the Caribbean is conflicting, due to the highly variable dosage regimens within less affluent countries. Areas that happen to have a psychiatrist are not likely also to have a pathologist or laboratory readily available, so the drug is generally given in lower doses than in the United States and without the benefit of serum level monitoring.

It was the experience of several panelists that there is a need to lower the lithium dosage in American patients who are traveling in the tropics or those who exercise and perspire excessively in the United States throughout the summer months. Patients appeared to enter into a new state of sodium balance once they shift climates. For American patients on normal salt and lithium balance in the United States, this can mean an increase of side effects and even toxicity if they shift to a tropical country and do not reduce their lithium intake or increase their sodium. This is because lithium metabolism is primarily sodium dependent and a depletion of salt for any reason can cause increases in lithium side effects or toxicity.

Most patient diets automatically accommodate to the increase in fluid and salt requirements, but schizophrenic and depressed patients may not, resulting in an increased likelihood of side effects with antidepressants, tranquilizers and lithium with a given dose/body weight used in the United States.

With respect to psychological or placebo differences (which account for 20 to 30% of drug response) the panelists reported that the side effects can take any form in any patient in any culture, depending on the personality patterns and psychodynamics of the person and the learned expectations of what a given drug is supposed to do.

Caribbean patients view mental illness as something external that is done to them, and they therefore find it difficult to take drugs in general. Once they do start to take medication, like in the American culture, 30 to 70 percent of the patients do not take the medication as they should. The availability of blood levels for some medication should improve this poor statistic. Where they do take medication, the uneducated from both cultures may develop placebo side effects referable to head, gastrointestinal tract or any organ system that the subculture and family have determined as a helpful or harmful consequence of taking medications. In summary, comments of the panelists with respect to cross-cultural differences and side effects of drugs are borne out of the personal experience of the participants and not out of any precise scientific study. If the reason for this joint meeting is to truly increase understanding and scientific knowledge between the various cultures, then our panel wishes to point out the great urgency to teach what is already known about psychopharmacology to all the islands in the Caribbean and to encourage the launching of a new collaborative transcultural research program in psychopharmacology.

VOODOO, SPIRITUALISM AND PSYCHIATRY

A Summary of a Panel Discussion

James R. Ralph

Animism and beliefs in spirits have existed in every known culture. The witch hunts of Salem, Massachusets are an example of these beliefs in our own country from the not-too-distant past. These traditional beliefs are still active in parallel with other religious, philosophic and scientific world views. As a basis for further discussion of contemporary belief in spirits, members of the panel visited an *espiritista* temple in San Juan. During the temple visit the group was given the opportunity to see first hand the work of an *espiritista*, with whom a case of psychic surgery was also discussed. This experience was very enlightening since, according to the Puerto Rican psychiatrists in attendance, many Puerto Ricans manifesting psychiatric symptoms present themselves or are taken by family members to an *espiritista*. *Espiritistas* outnumber available mental health professionals in many Puerto Rican communities and are frequently the only help sought for emotional disturbances.

According to the *espiritista* doctrine, spirits are intelligent beings who reach perfection through many reincarnations. These spirits can be good or evil, and can affect the living. One can communicate with them and cause them to modify their activities through the help of a medium—a person with powers of divination and the ability to contact the spirits.

Patients suffering from psychosomatic ailments, neuroses or psychoses will go to a seance, a ceremony attended by four types of persons: (1) a medium in charge, (2) an assisting medium, (3) a follower with divination skills, and (4) a follower without divination skills. The meeting is opened with prayers and exaltations to set the mood. During the readings, mediums may become agitated, grimace, hyperventilate or yawn in an exaggerated manner; this behavior eventually develops into a trance. The onset of healing is anxiously awaited for; it starts by voicing a reaction to visual hallucinations or somatic discomforts. It may be experienced by anyone with divination skills, and may refer to anyone in the audience, a relation or friend present or absent. The seance continues with one medium or more entering into a trance, searching into the supernatural for the evil spirits responsible for the client's miseries; the audience exhorts the spirits to leave their hosts. Thus, the seance offers meaning and dignity ~~to the~~ person and a way of reaching

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the symptoms of mental disorders in a socially and culturally approved fashion.

Upon returning from the temple, a film entitled "Possession" was presented, which described the activities of an *espiritista* in New Jersey. Group discussion centered on the phenomenon of *espiritismo* in terms of psychodynamic theory with particular emphasis on the development of a world view and the synthesis of the self.

The practice of witchcraft was also discussed, which in the West Indies is known as Obeah. It has its origin in Ashanti religious practices brought from Ghana by slaves. The Ashantis worshiped a supreme being, but accepted the existence of spirits which could take possession of man, causing emotional disorders. When the Ashantis were brought to the New World as slaves, all forms of native religion were repressed. Myalism was the name given the old tribal religion of Ashantis. Myalism and Obeah were repressed by the plantation owners and white men. The Myal leader was primarily concerned with the welfare of the community, while the practitioner of witchcraft was empowered to do both good and harm to individuals, with emphasis on the latter. Today, Obeah men are reputed to cause and cure illness, kill people by myriad means, drive people crazy and counter spirits of other Obeah men.

A case presentation was made of a 14 year old Black native Virgin Island girl who manifested progressively more disturbed behavior since her incestuous rape at age seven. Since the patient stole frequently, her mother attributed her behavior to an Obeah curse placed on her daughter by one of her enemies. The girl's eventual recovery demonstrated how the alternatives offered by school, welfare, psychiatric and correctional agencies all had failed. She recovered following conversion to a fundamentalist sect which helped break her psychotic state.

Because of time limitations, the practice of Voodoo was only briefly touched upon. However, it was noted that Voodoo, which originated in Haiti among African slaves, was once characterized by the veneration of snakes. Snakes were thought to symbolize the supreme power in the world. Snake worship has almost disappeared. Ritual dancing, accompanied by the famous Voodoo drums, has assumed major importance in modern Voodoo rites.

In summary, there was a consensus among participants that a mental health professional must know more about an individual's cultural background if he or she is to be effective. The point is obvious when one considers a person from a society which has institutionalized the belief of good and evil spirits and the practice of witchcraft, but is just as true when dealing with persons in the United States who are significantly, though not as obviously, culturally different. Mental health professionals must accord respect to all belief systems which link individuals to socially validated world views and which provide meaning to their own, very human, experience.

PSYCHIATRY AND THE CRIMINAL JUSTICE SYSTEM: THE INVISIBLE BARRIER

A Summary of a Panel Discussion

Roger Peele

The theme of our panel was a transcultural study of the psychiatric society and the legal society. Separating the two are barriers that are invisible to the uninitiated, so that both lawyers and psychiatrists have tripped and stumbled at the interface. Maybe there is no other area in which both professions have been more poorly prepared and no arena that has more frequently made psychiatrists and lawyers look foolish. Although our primary focus was the criminal justice system, other interfaces of the law and psychiatry, such as civil commitment and malpractice, contain many of the same invisible barriers. The invisible barriers consist of four differences between the law and psychiatry: different goals, different assumptions, different definition of key words and different ways of approaching a problem.

The goal of the mental health system is the care and treatment of the mentally ill, whereas the goal of the judicial system is to achieve justice. For our purposes in talking about the criminal justice system we identified two subgoals—punishment and rehabilitation. The judicial system assumes that it is important to exactly define one's terms, whereas the mental health system may not. The individual psychiatric practitioner, for example, feels no more need to define "mental health" before he treats than an artist feels he has to define "beauty" before he can paint. The mental health system uses a deterministic model of the mind because deterministic models provide predictability of therapeutic interventions. Second, we do not use the concept of an evil mind. Yet, the judiciary assumes behavior is rational, assumes a free will, which by definition cannot be a deterministic model, and believes in an evil mind. Allied with an evil mind is the identification of guilt. The concept of guilt can even be argued as one of the characteristics of human freedom. On the other hand, the psychiatrist is often not interested in establishing guilt, but in modifying or abolishing it.

The law follows Stuart Mill's assumption that "freedom" means a lack of mechanical restraints, whereas the mental health worker usually sees "freedom" as a lack of physiological or psychological restraints. The judiciary's "right to treatment" means just that to them, whereas on inspection, the mental health profession believes it really means the "right

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to no treatment." "Truth" in psychiatry is usually measured in gradations, whereas the law tends to ask for absolutes – guilty or not guilty – dangerous or not dangerous. The Baxtrum decision in New York, for example, released 900 people labled "dangerous." To date there have only been four killings as a result of this mass release. Many have heralded this as proof that the 900 people were not dangerous, but would the relatives of the four who were killed agree? The determiners of truth in the mental health system are experts, whereas the determiners of truth in the judiciary are judges and juries – the latter usually being pruned of any expertise. The judicial system uses a rationalistic approach to finding truth, whereas the mental health system uses an empirical approach. The judiciary's process of finding the truth is an adversary one, whereas the mental health system uses consultation and coordination.

These differences produce misunderstandings that are perceived by abuses by both. You will recall we identified two subgoals of the criminal justice system – punishment and rehabilitation. Many psychiatrists claim that these two goals are not compatible and suspect that the mental health professions are being abused by the judiciary's efforts to have it both ways. But the abuse that most upset our discussion group was a concern that the criminal justice system, in the face of deviances, authorizes mental health services for the well-to-do and authorizes prison for those same deviances in the lower class and among minorities. The interactions of the judiciary and psychiatry seem to say to the middle and upper classes: "Give them health," and to the lower classes and minorities: "Give them justice."

A factor in the relationship is mutual lack of admiration. For example, the mental health professional sees the criminal justice system as no system at all, but one of chaos and turmoil. If we had had some judges in the group, they would have been no more generous in their description of the mental health system.

Given the differences in the two fields, it was felt that the members of both these cultures need greater exposure to each other in their training years. However, we were warned by a group member who had both a law degree and a medical degree that the differences in the fields are so profound that one cannot think in both systems at the same time.

The group had an approximate concensus in listing the invisible barriers and abuses, but there was much less concensus on solutions. Several proposals had a general theme of warning the psychiatrist not to be pulled into making the judiciary's decisions: do not decide guilt and do not decide dangerousness, but use ploys that force the judiciary to make its own decisions. A second gambit is to force the advocates to become the responsible ones. For example, an advocate, for freeing someone found not guilty by reason of insanity should, if possible, be put in the position of being responsible for that patient when he is released. Another proposal was an amalgamation of the law, psychiatry and social work, having all three sit together as judges. A different solution focused on process. Psychiatry is spending too much time reacting and too little time initiating. Good initiating, obviously, calls for being part of the process at the early stages. Too often psychiatrists fail to become part of the early planning stages. We must keep in mind that early planning is the form of the change agent and the advocate.

It was hoped that we could formulate a resolution that would move the psychiatric profession in the direction of improving its interface with the judiciary. That never evolved, but describing an actual ongoing program might be better than a position paper anyway. Such a program has been developed in Puerto Rico, and is called TASC—Treatment Alternative to Street Crime. Dr. A. Gregorio Gomez is working with a diversionary program for addicts in which, in agreement with judges and the addicts themselves, 332 addicts have been diverted tentatively, based on their future behavior, from the criminal justice system to the mental health system which provides detoxification in jail and a residential, drug-free therapeutic community outside jail. Although a perfect record cannot be maintained, after six months *none* of the 332 have been rearrested. Since writing this, Bertram Brown pointed out to me that the Director of the Department of Addiction Services in Puerto Rico is a lawyer, Mr. Santos del Valle. This raises a question as to whether this organizational interdigitation between law and psychiatry is a key element to the program's success.

Although a theme of this conference was to focus on what psychiatric services need to be developed for Spanish speaking populations, our discussion group felt that the program developed for Spanish speaking addicts in Puerto Rico should be brought stateside as a model, and used with English and Spanish speaking addicts alike. The potential of such a model in the treatment of other nonviolent criminals was also felt worthy of exploration.

THE ABUSED AND NEGLECTED CHILD

A Summary of a Panel Discussion

Henry P. Coppolillo

There were approximately 18 discussants at the workshop on child abuse and neglect. The participants came from the fields of social work, psychology, psychiatry and other medical specialties. During the course of the meeting we had the opportunity to discuss child abuse as a phenomenon, factors which influence detection, reporting and treatment of child abuse and neglect, and the measures that might be undertaken to prevent and cure child abuse as a cultural or social illness. While it would be legitimate to expect that after 14 years, child abuse and neglect would have become universally recognized and defined, the discussion group was forced to acknowledge that this is not the case. While some felt that the willfull, nonaccidental inflicting of injury on a child was the essense of child abuse, and that the withholding of provisions that are necessary for the child's optimal growth and development constituted neglect, others did not agree with this narrow definition. There were some who felt that political insensitivity, economic deprivation, inadequate care of children's societal needs and other such phenomena also must be understood in terms of abuse or neglect. Our group also noted that while abuse was widespread and numbers of reported cases are reaching epidemic proportions, there is still an astounding ignorance in our institutions and in our society about the phenomenon.

There was a discussion about the forms and manner in which children have been abused in western civilization for the past 2500 years. The castration of male children to produce church choir sopranos, the selling of children into slavery, the workhouses and collieries of England and the United States were cited as examples.

It was not until 1962, when Kempe and his coworkers described the phenomenon as the battered child syndrome, that legislation was passed which both formally acknowledged the medical world's interest in these children and attempted to arrest the syndrome's tragic evolution by making reporting mandatory and instituting procedures for the protection of children.

It was stressed several times that the reporting of child abuse is increasing. Whether this reflects an actual increase in incidence and prevalence, or simply better modes of detection and reporting, cannot

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be ascertained at this time. However, it was emphasized that child abuse and neglect can and does occur in all strata of society. What was painfully clear was that when lower socioeconomic groups come to the attention of medical and social systems, child abuse is more likely to be detected and reported than when people from the upper strata of society seek medical assistance or make contacts with other institutions.

The various participants on the panel gave many examples and illustrations of the ways that the inadequacies and injustices of our social systems permit child abuse to occur more frequently. Such issues as inadequate prenatal care for indigent mothers, inadequate health and housing facilities for lower socioeconomic groups, inadequate facilities for temporary care of children, the breakdown of the extended family with few or no substitutes available to parents of young children, were among a number of issues raised. It became eminently clear that these inadequacies and injustices were not confined to societies that were "poor" or "developing," but extended to even the most affluent societies in the world.

One of the Puerto Rican participants gave a vividly poignant description of a neighborhood in San Juan which could be used as a model to describe how societies have abandoned and isolated their needy and poor. The feeling of despair was palpable as she told how medical personnel, social welfare workers and even police were reluctant to enter this area and how people could disappear into such a neighborhood, losing contact with all caretaking agencies and even the municipal or state authorities. As these neighborhoods were discussed, the point was made again and again that they were virtually ubiquitous and part of every major city.

In addition to descriptions of neighborhoods, scrutiny of populations living in these neighborhoods raised the issue of massive distrust of authority and their unwillingness to report child abuse and neglect. In a word, the description was that of a population who felt that they had little or no rapport with the established authorities or their delegates.

It was generally felt that not only were troubled families' needs as yet unmet in most societies, but also that there were discrete children's needs and rights that were being ignored. Rather than list these, the discussion focused on ways that these needs of children could be met and their rights protected. It was generally felt that all cultures needed to implement a system of advocacy for those children whose families cannot serve as their advocates. This system should be empowered to protect children from unwarranted institutionalization, abuse, neglect and to insure their rights to health care, adequate nutrition, adequate schooling and a measure of serenity and tranquility in their lives.

An issue which was discussed at length in terms of its political, religious and cultural implications was the problem of adequate contraceptive information. It was widely felt that child abuse occurred more frequently among those people who did not want or could not tolerate a child at a particular stage in their lives. Many times the ability of these people to use contraception effectively is interfered with by ignorance, religious conviction or simple economic inadequacy. The most complex aspect of this problem was, of course, felt to be the religious and cultural aspect.

The need for prenatal care is an important issue in the genesis of child abuse in that children who are born enfeebled or unhealthy have much less capacity to stimulate and gratify parents. The birth of a weakened or damaged child increases the incidence of detachment and hostile responses on the part of these parents, and when this occurs, child abuse and neglect increase in probability.

The physical and psychological well being of a child does not occur automatically. Especially in certain high risk populations, equal care for children means more than average care. Parents must have ready access to medical and welfare systems that will provide help to the child and to the parents themselves as they need it. This help should be designed not only to minimize the destructive effects of disease, but also to maximize the potential every child has for a full, happy and productive life. This care must not only be physically available to the parents who request it, but programs of educating people about how to use care are essential.

Illness, handicaps and situations of want are constant companions of abuse and neglect. A vigorous, healthy child who takes developmental steps with joy and enthusiasm inspires parents with tenderness and pride. For some parents it will be the first time they experience these human affects. Keeping the child in the condition in which he can take these steps may mean the difference between a family that survives socially and one that succumbs.

The group was well aware that there was no "cure" for child abuse and neglect, since suffering could never be undone. However, we felt that there were steps that could be taken that would stop the abuse in particular instances and that could set long range goals designed to prevent the syndrome before the damage could take place.

Curative steps that can be taken in instances in which abuse has already occurred were enumerated.

1. Adequate legislation to facilitate reporting of abuse exist in many states. All states should be encouraged to review their laws periodically to ensure that they have incorporated social and medical advances and knowledge.
2. Systems of protection for child and parents must be developed in social welfare institutions and in courts. Moving away from punitive attitudes of retribution to curative, reparative concepts will lead to benefits for parent, child and eventually society.
3. Recruitment and compensation for well-trained workers to translate these programs from paper planning to field work is essential.
4. Programs which have been widely employed with clear measures of success should serve as models for communities which are starting their efforts in this direction.

Prevention of child abuse and neglect must be our ultimate goal. It is clear that favorable conditions for optimal growth and development must precede the arrival of the child. These conditions must be provided through education, medical care, social welfare programs, legislation, etc. Families must learn that wanting a child is a positive, active commitment that involves a choice rather than a simple submission to the laws of nature. Once that choice is made every resource of society must be at their disposal to ensure that their child will have the best chance to thrive in a comfortable environment where it is wanted and cherished. If the adults unto whom these responsibilities have been thrust by nature cannot meet them due to ignorance, illness or despair, then those institutions upon whom these responsibilities have been thrust by our commitment to civilization must meet them.

We must become convinced that no single segment of our society can prevent child abuse and neglect. All of society must commit some of its resources to this problem in the future. It must do so because our children are synonymous with our future.

LIST OF CONTRIBUTORS

Vicente Abad, M.D.
Clinica Hispana
Connecticut Mental Health Center
Hartford, Connecticut

Frank X. Acosta, Ph.D.
Assistant Professor
Department of Psychiatry
USC School of Medicine
Los Angeles, California

Ana Anders, M.S.W.
Coordinator for Spanish Speaking Patients
Saint Elizabeths Hospital
Washington, D.C.

Victor Bernal y del Rio, M.D.
Executive Director
Puerto Rican Institute of Psychiatry
San Juan, Puerto Rico

Harvey Bluestone, M.D.
Director, Department of Psychiatry
The Bronx-Lebanon Hospital Center
Bronx, New York

Elizabeth Boyce, M.S.W.
Senior Psychiatric Social Worker
Clinica Hispana
Connecticut Mental Health Center
Hartford, Connecticut

Bertram S. Brown, M.D.
Director
National Institute of Mental Health
Rockville, Maryland

R. W. Burgoyne, M.D.
Assistant Professor
Department of Psychiatry
USC School of Medicine
Los Angeles, California

William P. Cagel, M.D.
Olive View Community Mental Health Center
Los Angeles, California

John C. Chatel, M.D.
Medical Officer (Psychiatry)
Division of Forensic Programs
Saint Elizabeths Hospital
Washington, D.C.

Henry P. Coppolillo, M.D.
Professor and Director
Child Psychiatry Division
University of Colorado Medical Center
Denver, Colorado

Ronald Fieve, M.D.
Professor of Psychiatry
Columbia University
New York, New York

Alfred M. Freedman, M.D.
Professor and Chairman
Department of Psychiatry
New York Medical College
New York, New York

Moises Gaviria, M.D.
Assistant Professor
Psychiatry and Preventive Medicine
Abraham Lincoln School of Medicine
Chicago, Illinois

Mary Gentile, M.A.
Coordinator, Day Treatment Program
Pilsen-Little Village Community Mental Health, Inc.
Chicago, Illinois

Robert W. Gibson, M.D.
President
American Psychiatric Association
Washington, D.C.

Richard Hoerl, Ph.D.
Director, Outpatient Services
Northwest Denver Community Mental Health Center
Denver, Colorado

Pablo Holguin, M.S.W.
Clinical Director
Pilsen-Little Village Community Mental Health, Inc.
Chicago, Illinois

Richard G. Johnson, B.S.
Research Assistant
Department of Psychiatry
USC School of Medicine
Los Angeles, California

Frank Kline, M.D.
Associate Professor
Department of Psychiatry
USC School of Medicine
Los Angeles, California

Edward G. Long, M.D.
Associate Director, Psychiatric Services
Northwest Denver Community Mental Health Center
Denver, Colorado
James Maldonado, M.S.W.
Department of Psychiatry
Lincoln Hospital
Einstein College of Medicine
Bronx, New York
Raymond Manning, M.D.
New York Hospital
Cornell Medical Center
Judd Marmor, M.D.
Franz Alexander Professor of Psychiatry
USC School of Medicine
Los Angeles, California
Amado M. Padilla, Ph.D.
Associate Professor
Department of Psychology
University of California
Los Angeles, California
Eligio R. Padilla, Ph.D.
Assistant Professor
Department of Psychiatry
University of California
Los Angeles, California
Rafael J. Parlade, M.D.
Director
Nichols-Haydon Division
Saint Elizabeths Hospital
Washington, D.C.
Roger Peele, M.D.
Acting Superintendent
Saint Elizabeths Hospital
Washington, D.C.
Beatrice Purdy, A.C.S.W.
Chief Psychiatric Social Worker
The Bronx-Lebanon Hospital Center
Bronx, New York
Thomas Radinsky, Ph.D.
Assistant Director, Research and Evaluation
Northwest Denver Community Mental Health Center
Denver, Colorado
James R. Ralph, M.D.
Chief, Center for Minority Group Mental Health Programs
National Institute of Mental Health
Rockville, Maryland
Juan Ramos, Ph.D.
Deputy Director
Division of Special Mental Health Programs
National Institute of Mental Health
Rockville, Maryland
Alvin H. Richmond, M.S.W.
New York Hospital
Cornell Medical Center
Mishelle Ross, M.A.
Department of Psychiatry
Lincoln Hospital
Einstein College of Medicine
Bronx, New York
Fred Staples, Ph.D.
Department of Psychiatry
USC School of Medicine
Los Angeles, California
Walter Tardy, M.D.
Department of Psychiatry
Columbia University
New York, New York
John Tirado, Ph.D.
Administrative Assistant
Pilsen-Little Village Community Mental Health, Inc.
Chicago, Illinois
Albert Vasquez, M.S.W.
Executive Director
Pilsen-Little Village Community Mental Health, Inc.
Chicago, Illinois
Luis H. Velosa, M.D.
Medical Director
Child/Adolescent Services
Mental Health Services for Kings County
Hartford, California
George Wolkon, Ph.D.
Department of Psychiatry
USC School of Medicine
Los Angeles, California